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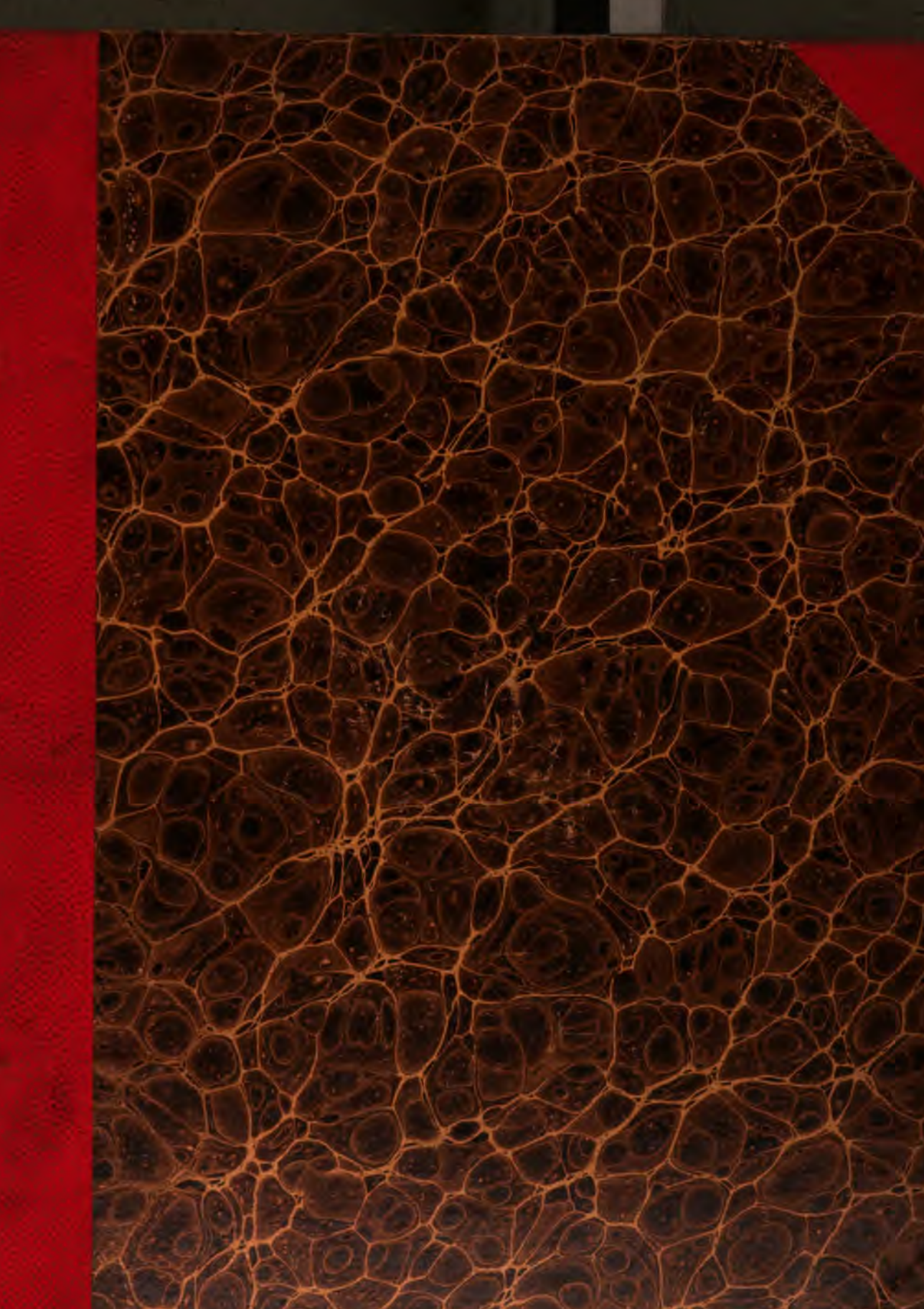

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FIBRINOUS POLYPOID UTERINE TUMOUR—SECONDARY HEMORRHAGE REMOVAL OF TUMOUR.*

BY A. D. LEITH-NAPIER, M.D. ETC., DUNBAR.

NARRATION OF CASE.—Mrs. M., wife of an actor, æt. 22, pale, little, blonde; secundipara; was easily and naturally delivered of a healthy female child on 30th May, 1881. The placenta came easily and was entire; the membranes untorn. In size the placenta seemed rather small, but appeared quite healthy. Mrs. M. originally a weak, fragile woman, of nervous temperament, had been confined of her first child sixteen months prior to the second delivery. She nursed her first baby nine months. Lochia lost colour on fourth day; mother nursed child; milk sufficient; pulse and temperature normal, average 80 and 98°. In consequence of her husband's pecuniary embarrassment at time of her confinement, she had no regular nurse, and possibly exerted herself more than was prudent from the very first. However, she did exceedingly well up to 9th June, (the eleventh day); she rose on that day, but did no house work. In the evening she carried her little boy across the room, and thoroughly washed him; she felt very tired after doing so. Between three and four hours after this bleeding began. I was sent for about 11.30 p.m. On visiting I found my patient reclining in an arm chair, in a profound faint; no pulse at wrist; face pallid as death. The quantity of blood lost was very great; but as she had been sitting up, fully dressed, when hemorrhage commenced, it was impossible to estimate how much, even approximately. The whole of her clothing from below the waist was saturated; the chair, covered with leather cloth, contained a large pool, and from it the blood had streamed over the floor. The faint lasted for several minutes after my arrival, although on my seeing her she was immediately placed flat on the floor, with her head low. Upon recovering consciousness, the clothing was removed, and she was gently lifted into bed. On examination the vagina was filled with clots, as was also the lower uterine cavity; two fingers could be easily introduced within the os. The uterus felt about the size of a fœtal head. By external and internal manipulation many clots were removed, the uterus contracted, and was fixed by a pad and roller. The following was prescribed—

℞ Ext. Ergotæ fl. ʒi
Tr. Hamamelis ʒss.
Aq. ad. ʒij.—M.

Sig. Two teaspoonfuls at once, and one teaspoonful every two or three hours. Cold water cloths were applied to the vulva for an hour and half. After remaining an hour I felt satisfied that bleeding was checked and left. During the night, and next day, several small clots were passed, and about six or eight napkins used. On 11th June two or three cloths were required; on the day following the discharge ceased. Mrs. M. continued to nurse her baby, but was strictly enjoined to maintain the recumbent position in bed. On 13th June, about 2 p.m. I was again sent for. I found the patient sitting up in bed. She was very nervous; bleeding recommenced with much severity about half an hour before. Fully twenty napkins were used; half of the number perfectly soaked. The vagina was cleared of all clots; two fingers introduced *in utero* and some clots, half the size of a hen's egg, removed. The uterus was not nearly so large as on the former occasion. I learned she had only taken her mixture for 48 hours. She had been wholly in bed; but had been "obliged to sit up frequently to attend to baby, as she was fretful." A full dose of ergot was given, and the former mixture ordered to be taken every four hours, also whiskey frequently.

14th June—Clots passed in early morning; discharge very moderate. As her strength was seriously impaired, she was advised to wean her baby.

15th and 16th June—Color of discharge brownish, only one napkin in the twenty-four hours.

17th—Lochia brighter; two napkins through day. 19th—Color almost gone; one napkin in twenty four hours. 22nd—Small quantity of "slimy discharge." 24th—Feeling well; rose; no

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discharge. 25th—Very slight discharge. 26th—Rose about noon; up two hours; bleeding began necessitating two or three napkins; went to bed, but bleeding continued profusely; after a time it gradually ceased; there was then "a very free clear watery discharge; about 8 p.m. a large blood clot was passed." I visited about 10 p.m., by this time the bleeding had almost ceased. P.V. examination; after removal of some clots, a pyramidal fixed mass fully occupied the cervix; the uterine tissue was soft, and it was possible to introduce two fingers within the os. The surface of the mass felt rough. The uterus could not be felt distinctly in the hypogastrium. In consequence of the feeble state of the patient, a prolonged examination was deemed inadvisable. The vagina was plugged; full doses of ergot and witchhazel ordered. The handling of the tumour caused little pain; patient stated she "had severe pain in the belly to-day, before and after the bleeding."

27th—Feeling pretty well. To ascertain the exact nature of the tumour, a sound was used; it passed two and-a-half inches within the uterus. The diagnosis being clear; the tumour was fixed by forceps, and twisted off, with little difficulty. The growth was, roughly, the size of a hen's egg, and was encapsuled in a distinct membrane.

2nd July—Patient exceedingly agitated, on account of a drunken row in lodging-house, but no recurrence of hæmorrhage. The subsequent history contains nothing of note; in fact, from the removal of the tumour she progressed most satisfactorily. On the 13th July she was able to take a longish walk.

REMARKS—The whole subject, and especially the pathology of fibrinous uterine tumours requires so much consideration that I sent the tumour for minute examination to Dr. Woodhead, who after careful observation reported as follows:—"The tumour appears to consist of two factors, a piece of placenta and large masses of coagulated blood. Near the surface of the tumour is an appearance somewhat like that very roughly washed in on the other side. The pink being the placental structure in which are a number of connective tissue, and it appears to me, muscular fibres. The villi are covered with a layer of flattened epithelium and are cut in various directions. In some parts of the section there are numerous cells apparently from the wall of the uterus which are undergoing the coagulation necrosis, *i. e.* are with the fibrine forming a coarse net work, the coarse strands being formed by fibrin and the periphery of the cell, whilst in the centre of the mesh is frequently seen the nucleus with a small quantity of granular protoplasm. This cannot be accidental, as it occurs at several points and in every specimen I have examined. It is very like the net-work formed in diphtheria. The remainder of the tumour consists simply of coagulated blood which has been thrown out at different times, for in some cases the coagula are much more distinctly seen than in others. Delicate bands of fibrin, form a net work more or less dense and perfect, in which lie the coloured and a few colourless blood corpuscles" Dr. Woodhead, who was most kind in thoroughly examining the tumor, wrote me further that he considered the cells to be "epithelial, not muscular, in character," "those lining the uterus and probably some of the glands." I was most anxious to have the opinion of an expert microscopist, as I have found very great confusion in literature regarding the variety to which some of these tumours should be referred.

On macroscopical examination the tumour which was fully as large as a hen's egg, appeared to me more like a small fibro-cystic growth than a fibrinous polyp. I noted that what seemed to have been a cyst was for the most part occupied by a reddish bloody stratum, this stratum evidently having been formed from extravasation of blood within the cyst; the membrane forming the cyst wall was well developed. There had evidently been discharge of part of the contents of the cyst, as the dense coagulated blood and fibrinous appearance, together constituting the main part of the tumour, did not wholly occupy the investing membrane. My rough microscopical examination, before proper hardening, shewed bands of tissue somewhat like fibro-muscular structure, but this has been more exactly described in Dr. Woodhead's report.

Having determined the morbid anatomy of the growth, its pathogenesis next demands notice. The most natural theory is that a growth shewing evidences of placental structure is more or less a product of the placenta. It is well known that polypoid formations are a frequent result of one or more pieces of placenta having been left *in utero*. It is also equally well known, that at times portions

of retained placenta may sustain existence for a considerable time ; not only existing *in utero* but so to speak persisting in vitality. For example, in one case a lady was sent to the seaside for the recovery of her health and the stoppage of hemorrhage, some weeks after abortion. A more severe attack of bleeding led to an examination ; when a piece of placenta fully the size of a walnut was found lightly held in the cervix ; on its removal bleeding ceased. But in the above case we have more than simple placental structure ; a distinct evidence of cell formation, which cells were evidently derived from the uterus, and also some muscular fibres. The presence of smooth muscular fibres in the placenta has been described by Ecker and Kamenew ; but denied by subsequent inquirers. Stricker states that his own researches demonstrate their presence to be constant in the external layer in the placenta uterina. I think it probable that the muscular fibres here described were uterine. In addition to the placental, there was the aforementioned hemorrhagic portion encapsuled in a distinct membrane. We may assume that the interpretation of the " coagulation necrosis," which Dr. Woodhead remarks on as notable, is, that post-partum the vitality of the growth was checked, and that nature was preparing for its expulsion. So that we may premise that the tumour had an ante-partum existence distinct from the fœtal placenta. Small fibrinous coagula intimately blended with the projecting thrombi at the placental insertion, are quite commonly found in the bodies of puerperal women. But larger coagula also, the result of repeated hemorrhages, the size of a walnut, either of a round shape, or flat and lobulated, which may also project into the uterine cavity like a cockscomb, are by no means rare. These cases only are very rare where large fibrinous coagula of a polypoid shape are seated at the normal placental insertion and project with their obtuse end into the cervix or vagina. A fibrinous polypoid of that kind—the free polypus hæmatoma of the uterus (Virchow)—consists of coagulated fibrin including a nucleus of coagulated blood. Polypoid formations, from retained placenta, may undergo further modifications. Upon the pieces of placenta blood may be deposited in the way just mentioned, and a fibrinous polypus is formed with a pedicle of placental tissue, or the retained cotyledon may become bloodless, firm and hard, and assume a shape corresponding to the uterine cavity. This forms the so called placental polypus.

A few words regarding the changes in effused blood. It may remain liquid for some time, or quickly coagulate. Formation of cysts may take place, not so much in the effused blood as in the surrounding parts. Those which are at first ragged and torn, undergo more or less of inflammation, which ends in the formation of a solidifying blastema ; this fibrillates and passes into the state of more or less perfect fibrous or areolar tissue, and thus forms a capsule or cyst enclosing the now more or less altered blood. Rokitansky describes the later appearance of the lining as like a delicate serous membrane—Hæmatoma. The effused blood may undergo a different kind of change, in consequence of absorption of its watery parts, and become in this way a kind of tumour, termed an hæmatoma, classed with new growth ; but there is no doubt that it is a simple result of hæmorrhage, and this for three reasons—(1) that it presents no higher structure than that of fibrine ; (2) that it is generally devoid of vessels ; (3) that it does not appear to increase by growth in the proper sense of the term. The inner parts ultimately undergo some form of degeneration, while the outer form a fibrous investment. An hæmatoma thus formed (*i. e.* in the substance of new tissues, etc.,) being essentially a fibrinous mass, may undergo certain other changes—cretification, melanic pigmentation, perhaps ossification—(Jones and Sieveking). Some consider it doubtful whether such changes as bone formation, etc., can take place from blood effusion. Without expressing an opinion on this point, I conceive it might be well to retain the name 'hæmatoma' to bloody tumours in loose tissues e. g. the vagina, vulva or scalp. As a mere question of pathology the so-called polypoid uterine hæmatoma is diverse from the condition found as a result of rupture of vessels and effusion into sub-mucous connective tissues as found in the one, and beneath the aponeurotic or pericranial layers in the other. No authority, so far as I know, has however observed distinct characteristic cell formation similar to the above described appearances, in a simple hæmatoma. That the tumour was in great measure of this nature is true, but, I think it would be erroneous to regard it as simply a hæmatoma ; and while it is plain that the growth was partly placental, it seems to me equally evident that its de-

velopment was inconsistent with the theory that it was derived from a portion of the main placenta. I think, if we believe in its formation from a placenta succenturiata, which some considerable time before labor had become wholly uterine in its connection, and at one time or other had undergone certain structural changes already referred to, we may best realize the genesis of the polyp. Twenty years ago Professor Hodge, of Pennsylvania, in his "Principles and Practice of Obstetrics," fully described the nature of placenta succenturiata. Dr. Eastlake has also (Obstet. Transact. Lon.) written regarding this anomaly. Schröeder writes "sometimes the placenta is divided even in simple pregnancy. Two or more, even seven placentæ have been observed; and at the side of a larger, several placenta succenturiatæ occur. These formations can easily be explained from the development of the membranes—some of the villi of the chorion not inserted at the place of the decidua serotina retain their vessels and enter into vascular communication with the decidua vera. If this does not take place the enlarged villi form the so-called placenta sparia."

POINTS OF PATHOLOGY are here also of interest. Unlike certain allied tumours, no special blood vessels supplied it; this was unnecessary as the growth had been, at first, in the same relation to the uterine circulation as the placenta normally is; but afterwards received a more direct blood supply from a uterine vessel or vessels. In connection with this, the grave bleedings which occurred when the tumour became partially detached can be understood more clearly. Generally the formation resembled that of an aneurismal clot, in which laminæ are formed by the variations in the rate of the coagulation or succession of coagulations, and in the paler portions the definite formation of fibrine gave rise to similar microscopical characters. But the existence of an internal cyst containing clear fluid requires notice. We know, that in not a few cases, cysts of various size are formed on the concave side of the placenta; the connective tissues between the chorion and amnion are raised cyst-like, and are lined by flat epithelium, whilst the placental portion assumes a rough, shaggy appearance, and is covered by fibrinous deposits. These cysts are thin transparent vesicles containing a yellow, or reddish-opaque, thin fluid. It is supposed that they are formed from apoplectic centres. One writer describing the "fleshy" species of polypi says: "they sometimes contain a cavity filled with fluid resembling mucous or lymph. This variety is however a most likely one to be absorbed during pregnancy." Paget's description of the formation of cysts in loose-textured fibrous tumours is also apposite: "they may be due to a local softening and liquefaction of part of the tumour, with effusion of fluid, or an accumulation of fluid, in the interspaces of the intersecting bands, but in other cases it is more than probable that their production depends on a process of cyst formation." Returning to the present case, it is probable the cyst was adventitious, that is the walls were formed by the condensation of the connective tissue of the part; it is also likely that the cystic fluid may have been serous, derived from the effused blood. If so the external investing membrane must have been, as we would expect, of earlier formation than the small internal cyst. The minute examination of the tumour shows that the different "probable sources" for the formation of uterine polypi, viz.: the connective tissue of the uterus, placental growths, and blood coagula, were all involved; and, as is remarked above, as a consequence of pathological changes in loosely bound together fibro-muscular tissue (?) a cyst may be formed. In further illustration of the benefit of sometimes "thinking twice before you speak once," or in other words making out the morbid anatomy ere you settle your ideas of a case, I may mention that various considerations caused me to regard the polyp as of post-partum formation on the one hand, and as possibly an ante-partum fibro-cystic growth on the other. The theory of post-partum development was suggested by the clinical facts that the placenta was removed with the greatest ease and seemed perfectly entire, there was neither uterine flaccidity nor hemorrhage post-partum; it seemed probable, if the tumour had existed in a condition of latency, it would either have been expelled with the secundines or have given rise to smart bleeding. On the contrary the uterus contracted well, and no symptoms of a growth were then noted. The puerperium was normal; involution seemed natural, the patient having "slimy discharges" for four days antecedent to the first mentioned bleeding. The post-partum formation of the body from a retained blood-clot seemed borne out by the symptoms. As has been already mentioned, poly-

poid growths are not infrequently observed when parts of the placenta are left behind. Schröeder perspicuously points out the time at which hæmorrhage is likely to occur—"it may be early, sometimes not till after the first week, more often after the second or third." But the placenta appeared to be wholly removed. I have paid some attention to secondary hemorrhages, and judged the first bleeding to be due to the cause I have described as "imperfect thrombosis," (Obstetrical Journal, No. xlvii. Feb. 1877). The patient had unduly exerted herself on the 11th day after delivery, involution having seemed normal previously; it was believed, that as a consequence of the exertion, one of the imperfectly thrombosed veins became partially open, and we might with fair grounds assume the formation of an hæmatoma as a result; theoretically, this having a well established uterine connection might become encapsuled in a layer of fibrinous connective tissue. It is evident that some thrombotic dislodgement actually did occur as shewn by the enormous bleeding. The remedies employed favoured vascular contraction; yet on the 15th day hemorrhage recurred; it was considered probable that the thrombus then became freed, and the separated polypus developed. From this time to the 28th day the blood-oozing was like that of sub-involution, or like surface bleeding of a polyp. The first, and only needful argument against this theory is the morbid anatomy; further, in accepting it, it would be necessary to believe that a polyp with such anatomy could be formed from blood clot in thirteen days. The other theory, viz.: submucous fibroid or fibro-cystic, was based on the ground that while fibrinous polyps are rare, and if present during pregnancy likely to cause abortion, or become absorbed, yet the existence of such has been recorded. Cystic growths are mostly cervical; and developed from the Nabothian glands or utricular follicles. But these follicles also exist near the openings of the Fallopian tubes, in the fundus, and upper part of the body; and granting an abnormal condition of the mucous lining, and a soft dilatable condition of the uterine walls, as was highly probable from the personal history of the patient, it was not impossible to conceive the tumor's formation in one or other of these ways. The examination of the growth put both theories quite out of court. The polypus was antepartum; but the post-partum influences, and the enlargement it received from secondary hæmorrhage demand attention. I do not think unless there had been undue exertion that the hæmorrhage would have been so serious; in saying so I would point out the existence of the dual causes of bleeding, secondary hemorrhage from the site of the polypus, and also from the imperfect thrombosis of an adjacent vein. To recapitulate, bleeding occurred on the 15th day, I conceive *not* from the vessel which was covered by the tumour, or at any rate from it only partly, most from a neighbouring vein. On the 28th day, when the polypus became loosened, blood gushed from the vein it had previously pressed on, and by covering, plugged; this bleeding was most profuse. The expulsion of the tumour from the uterine cavity was preceded by the discharge of clear watery fluid. After the partial detachment of the growth from the body of the uterus, a large recent blood-clot was expelled; this probably was the result of bleeding from the site of polypoid insertion. A practical point is, that, a firm blood-clot acts as an intra-uterine irritant assists in the production of contractions, and hence aids involution. An ordinary experience in cases of miscarriage of twins at separated periods, is the formation of such a clot. After one fœtus has been parted with it is not impossible that the other may reach full term. But this is very unusual; irregular involution or partial uterine atrophy takes place; thrombi are separated from certain veins; large bleedings occur. If appropriate treatment is employed a clot may form and bleeding cease, the uterus enlarges perceptibly thereafter; the same process of hemorrhage, decrease in size, clot formation and increase, may be repeated again and again, until the second fœtus is naturally or artificially dislodged. In the case under notice, the large blood clot was probably formed on the 26th June. It is to be observed, that after the escape of this clot, and the descent of the tumour within the cervix, bleeding ceased externally; the cervix was plugged by the polyp; nor was there evident internal hæmorrhage, neither collapse nor increased size of the uterus being experienced. We must recollect that the personal and parturient history of the patient favoured uterine weakness; she was a very pale, fragile, anæmic, little woman, frequently insufficiently nourished; she had barely sixteen months between her confinements, had nursed her first child fully nine months, so that she continued

to nurse two months after she became pregnant. Altogether apart from the polyp, she was a most likely subject for secondary hæmorrhage or subinvolution. With the history given, we may readily suppose how easy it was, with an original abnormality, for the tumour to develope.

THE DIFFERENTIAL DIAGNOSIS is very interesting, as, if my view is correct, we have here a combination of sub-involution, secondary hæmorrhage from irregular or imperfect thrombosis, and a polypoid tumour of placental origin. The early diagnosis pointed to secondary hæmorrhage, as the early puerperium was one of evidently good involution; the lochia lost colour on the 4th day; she was permitted to rise on the 9th day; and it was only after unusual exertion on the 11th day that bleeding began. Yet despite the foregoing observations, there must have been sub-involution, as it was possible to introduce two fingers within the os on the 11th day; the bleeding could not have caused such relaxation; had involution been normal, the os would have been almost closed; my experience agrees with authority that the os is normally closed on the 12th day. The uterus, prior to the removal of clots, was as large as a fœtal head; now it seems likely that the faint was most important in arresting the hemorrhage, not the occlusion of the os by a clot; so that we may believe that this bleeding was extremely rapid as well as severe. Several cloths were used on the following day, but only two or three on June 11th; next day there was no discharge. On the evening of 13th bleeding was profuse; the os was still patulous, but the uterus much less in size. The probable cause of this attack was, she had been sitting up in bed, and had neglected her medicine. The subsequent account of slight flow on June 15th and 16th, a little more on the 17th, and its gradual disappearance afterwards indicated involution. The bleeding which was so alarmingly profuse on the 26th, was clearly due to the new source of danger, the partially loosened growth. On this occasion the uterus was not felt in the hypo-gastrium except by bi-manual examination. Such irregular bleedings are met with in chronic inversion, but in acute post-partum inversion the history is different; this condition supervenes suddenly and with it we have hemorrhage and collapse. Partial inversion might occasion similar bleedings, but the organic condition would be explanatory, when the polypus was forced into the cervix it had much the feel of an inverted uterus. I was strongly reminded of one case I saw some years ago, with Dr. Nellis of Fraserburgh and the late Dr. Fiddes of Aberdeen, of chronic partial inversion; in many respects there was much similitude. The pain in handling an inverted uterus is much more marked; the roughness, said to pertain to inversion as distinct from polypus, was in the foregoing case of little help; the tumour by no means felt smooth; but the encircling band of uterine tissue was more symmetrically circular, and the relations of the vaginal parietes to the cervix more perfectly defined. However it was not until I had cautiously passed a sound 2½ inches within the uterus, that I felt justified in removal of the tumour. It is all very well to write in one's study of the "clear differences," but in this case at least there was nothing to prove that the body was not an inversion, which had been gradually formed and was eventually protruded, until the sound was used. From prolapsus the tumour was distinct, it occupied the neck, and the neck could be felt. With prolapsus there can be little risk of confusion, even although there should be an opening in the polyp, unless the latter occupies the vagina very fully. I am aware of the possibility of complications of polypus with prolapse and inversion; but there seems here no need of further reference. Nor do I think the "book" differences of polypus from vaginal hernias, cystoceles, or malignant affections require discussion. In chronic cases it is doubtless valuable to bear these in mind, but not with a narration like the above. The intra-uterine situation of the growth obscured diagnosis. Montgomery, fully thirty years ago, wrote "fibrous tumours formed in the substance of the uterus may thence descend, pass through the os, and form an ordinary pediculated polypus in the vagina." To him also we owe the fact that a "large polypus may make its first appearance immediately after delivery. Even with the additional facilities for diagnosis and knowledge we now possess, I think most will agree that until interference is clearly indicated, the policy of non-intervention is wisest. I fancy few would care to dilate and explore a recently paturient uterus, which had ceased bleeding, and judging from the discharges was undergoing involution. Had the polyp not appeared when it did, I would then have explored the uterus more thoroughly. I well know

that in all obscure cases of uterine hemorrhage an exhaustive examination is a hundred-fold less dangerous than is popularly believed. I have known cases where the impregnated uterus submitted to every abuse with impunity, even to an insertion of 10 grs. of lunar caustic to stop a supposed inflammatory condition, and, when profuse bleeding still continued, the artificial dilatation of the os revealed the true cause, a retained fœtus and an inflamed chronically enlarged uterus! Viewing our present case retrospectively, one might think had the os been dilated, the whole thing would have been cleared up much sooner; yet, although with the authority of Matthew Duncan to justify us introducing a carbolised exploring hand within the uterus shortly after delivery, and with my personal experience of the benefit of the practice, I would not consider a case of secondary hemorrhage, with os contracted down to two fingers' breadth, a suitable one for this measure, until all others had failed; and that the case diagnostically seemed so far one of this description must be patent. Cervical tears, which have recently—"British Medical Journal, Oct. and Nov. 1881,"—been a subject of discussion, as regards their frequency and treatment, between Montrose Pallen, and Henry Bennet, might have been included in differential diagnosis. These are seldom a consequence of natural labor in such subjects as my patient, and as a matter of fact there were none. Bleeding from varicose veins in the cervico-vaginal region is either tolerably early discovered, or so slight as to require little attention. It seems impossible to misjudge either of these conditions so greatly as to confound them with secondary hemorrhage proceeding from the interior of the uterus.

TREATMENT has in part been touched upon. The primary indications were to check the flow and keep the patient living; the details have been described. Exactly the same treatment is required for secondary hemorrhage and an intra-uterine growth, up to a certain point. As Churchill said "by these means some good may be done, just sufficient perhaps to enable the patient to wait for the descent of the polypus, with rather less risk than if nothing had been done. He however regarded ergot as a beneficial remedy of a special nature. I think the witch-hazel tincture, ordered with ergot, a most useful addition. I have had much satisfaction with this drug in all classes of uterine hemorrhage; even in malignant disease, it is fully equal, if not superior, to any remedy in restraining bleeding. A combination of hamamelis, with ergot and strychnia, and ferruginous tonics, combined with quinine is all in the way of medicinal agents likely to be of use. The long subject of removal of polypi by means of the various media employed, galvano-cauteries, ecraseurs, ligatures, canula, polyptomes, screws, scissors, or bistouries, need not now occupy us; it was found practicable to twist the tumour off after fixing it firmly; torsion, the simplest method of all, was found easy and satisfactory. There was no bleeding, and the operation was almost painless. The subsequent treatment was simply good nourishment, tonics, and rest. So well did these fulfil their aim, that on the 13th of July the patient was able to take a longish walk without fatigue.

[We are indebted to Dr. Aubrey Husband of Edinburgh, author of The Students' Hand-Book of Forensic Medicine, for the above interesting paper.]—ED. LANCET.

ABSTRACT OF A CLINICAL LECTURE ON A CASE OF THE "JUVENILE FORM" OF PROGRESSIVE MUSCULAR ATROPHY (ERB'S "DYSTROPHIA MUSCULARIS PROGRESSIVA").

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GENTLEMEN,—The patient whom I exhibit today, through the kindness of my friend, Dr. Wilkins, presents in a very marked degree all the essential features of a disease which has only recently been described. The case is one of what Erb calls the "Juvenile Form" of progressive muscular atrophy.

The patient is a male, aged 21 years. His occupation, up to the time he was compelled to cease working from his present trouble, was that of a farm laborer. His complaints are, weakness of his back and legs. He first noticed this weakness three and one-half years ago. At that time he experienced difficulty in dragging his body after his feet when getting into a carriage or in ascending a stair. He could, at this time, raise his feet without difficulty, but to move his body, he found it necessary to use his hands to drag

himself along. About two years ago he first noticed that he was very apt to fall, and on attempting to rise from the horizontal position he found it necessary to use his hand to drag himself up. He never suffered from any serious illness. He attributes his present trouble to a fall which he received three and one half years ago. On careful enquiry, however, he acknowledges that for a long time previous to this accident, he disliked ascending a stair, because he found it both difficult and tiresome. Two and one half years ago he received a second injury; on this occasion a weight fell on his head, rendering him insensible for half an hour, and giddy and stupid for several days. His parents are dead, but cause of death is unknown. He has a brother living and in good health. Had no sisters. As far as he knows there has been no similar trouble to his in any of his relations.

Present Condition.—You will notice the peculiar gait which he assumes when he walks across the floor: 1st, he walks with his feet far apart; 2nd, he walks on the front part of his feet, the heels being raised from the floor, and 3rd, the gait is of a more or less waddling character. Nothing abnormal can be found in connection with the circulatory, respiratory, digestive or genito-urinary systems. There are no symptoms of any affection of the brain or cranial nerves.

On stripping the patient the marked difference in the size of certain muscular groups is at once noticeable. In the upper extremities, the contrast between the well developed muscles of the forearms and the atrophied ones of the upper arms is very striking. The circumference of the thickest part of the upper arms is an inch less than the fore arms. A still greater disproportion exists between the muscles of the thighs and those of the legs, the circumference of either calf being an inch greater than the circumference of either thigh at he thickest part. The following muscles of the upper part of the body are in a state of more or less complete atrophy: The pectoralis major and minor, of each side, are considerably atrophied, especially the costo-sternal portion of the former. The lower half of each trapezius has almost entirely disappeared. There is scarcely a trace left of the rhomboids. The latissimus dorsi of each side is very much atrophied, as is also the whole group of the spinal extensors. The biceps of each arm is greatly wasted, and what there is left of it is in a state of active contraction, preventing the full extension of the arms. The brachialis anticus of each arm is also in a state of advanced atrophy; the triceps is only slightly affected. The coraco-brachialis, the supra and infra spinati, as well as the deltoids, are normal. None of the muscular groups in the fore-arms or hands have suffered.

In the lower extremities the following muscular groups are in a state of more or less complete atrophy: The glutei of both sides, and the ilio-psoas. The quadriceps of each thigh is more extensively atrophied than any other group in the lower extremities. The peronei of the right side are considerably atrophied, while those of the left side have escaped. The calf muscles are hypertrophied. When the patient is in the erect posture there is marked lordosis. All the atrophied muscles are firm. They are not the seat of any fibrillary twitchings. The patient is quite unable to raise himself from the horizontal to the erect position, even with the aid of his hands. He, however, can accomplish this by getting a support to his chin, and thus using the muscles of the neck to drag his body upwards. The patellar reflex is absent. The plantar reflex is exaggerated. While the cremaster and abdominal are normal on the right side and absent on the left. The epigastric reflex is present, but the scapular is absent. The atrophied muscles do not respond to the faradic current. They are *not*, however, the seat of the degeneration reaction. Sensibility is normal. There is no interference in the vesical or rectal reflexes.

You will at once notice the striking difference there is in the patient before you, and the one* whose case we enquired into last week, and whom most of you have seen. When comparing these two cases, it is at once observable that we have to do with dissimilar clinical pictures, although they are both frequently described as one and the same disease. The following are the marked points of difference between them: 1st, they differ as to the localization of the atrophy. In the patient affected with the spinal variety of the disease, the atrophy commenced in the small muscles of the hand, in

* The patient referred to is a man, aged 37, who has the ordinary spinal variety of progressive muscular atrophy. The wasting commenced three years ago in the small muscles of the left hand.

the interossei, thenar and hypo-thenar groups. The wasting is confined to these small muscles. In this patient the atrophy affects the trunk muscles principally, while the hand muscles are perfectly free from any form of wasting. They differ also as to the condition of the affected muscles. In the spinal case they are soft and flabby, while in our patient here they are firm, hard, and have a knotty feeling. In the man previously seen, the atrophied muscles are the seat of fibrillary twitching, while the muscles in this boy's case are free from these fibrillary movements. Another marked difference is that in the case of the spinal form there is neither true nor false hypertrophy of the muscles, while there is here, especially in the calf. Other points of difference are the ages at which they make their appearance. The spinal form is essentially a disease of advanced adult life, while the juvenile form is seldom or never seen after the twentieth year. They are both slowly progressive diseases; the juvenile is, however, much slower than the spinal variety. In the latter the periods of intermission are comparatively short and seldom, while in the former they are long and frequent. They differ also as to the complications that may arise during their course. Last week, when we were examining the patient affected with the spinal form, I pointed out to you that there was marked trembling of his tongue when he protruded it. This is sufficient evidence that there is commencing bulbar paralysis in his case, and is the beginning of a series of symptoms that will before very long lead to a fatal ending. In the patient before you no such complication exists. In all the cases of the juvenile form of progressive muscular atrophy described up to the present, no such complication has existed. Secondary sclerosis of the pyramidal columns is not infrequent as a result of the changes that take place in the spinal form. It does not occur in the juvenile form. When we come to discuss the pathology of the disease, it will then be clear to you why these complications are so frequently present in the one case and never present in the other. Another marked point of difference between these two forms of atrophy is the fact that one is much more amenable to treatment than the other, the juvenile form being much more likely to have a favorable ending than the spinal.

They differ also in their pathology. In speaking last week of the appearances found post mortem in the spinal variety of the disease, I mentioned that the essential change was a slowly progressive obliteration of the multipolar cells in the anterior horns of grey matter of the spinal cord. The local muscular changes were simple atrophy of the muscular fibres. There is no increase of connective tissue, no deposition of fat, and no hypertrophy of the muscular fibres. Now in the juvenile form the changes are wholly seated in the muscles. The multipolar cells of the anterior horns of grey matter remain free, as do also the peripheral nerves. The muscular changes consists in atrophy of the muscular fibres, with here and there fibres which have undergone hypertrophy. In advanced cases hyperplasia of the connective tissue is very marked, and lying between the connective tissue fibres is seen only a small quantity of muscular fibres in an advanced state of atrophy, which, however, still retain their transverse striation. The most important change is the hyperplasia of the interstitial connective tissue, and next to this is the deposition of a more or less quantity of fat. It is probable that the increase in the muscular fibres is the first phase of the morbid change, and that the later appearing connective tissue hyperplasia gives rise to atrophy of the muscular fibres. These changes, as we will presently discuss, are essentially those found in cases of pseudo-hypertrophic muscular paralysis, and the so-called hereditary form of progressive muscular paralysis. This hereditary form of muscular atrophy has been described by Friedreich and others, but it is essentially the same disease as we are now considering. When the disease is hereditary and sets in about puberty, the muscles affected are those of the upper arms and trunk, while if it sets in during childhood the atrophy is principally confined to the muscles of the lower extremities.

The disease commonly called pseudo-hypertrophic muscular paralysis, differs but little, if at all, from the disease with which the patient before you is affected. Clinically, the only difference appears to be, that in the pseudo-hypertrophic paralysis, we have lipomatosis, while in the juvenile form of muscular atrophy, hypertrophy is not necessarily present, and if present it is true and not false. If this is the only difference it is quite plain that it would be better to describe the juvenile form of muscular atrophy as being sometimes attended

with a true and sometimes with a false hypertrophy of the muscles, rather than describe two separate diseases. Pathologically there is no difference between them. They are both myopathic and *not* neuropathic disorders. All the recent autopsies in cases of pseudo-hypertrophic muscular paralysis agree in the particular that no changes in any portion of the spinal cord are present. The changes found being confined to the muscles and differing in no way (except in a great degree of lipomatosis) from those described as being present in cases of the juvenile form of muscular atrophy. Changes have been described as being found in cases of the pseudo-hypertrophic paralysis in the ganglion cells of the anterior horns, but this was some years ago, and before the much improved methods of the histological examination of nervous tissue were known. Seeing that in a number of recent cases examined by such competent observers as Recklinghausen, Schultze, and Ross, where improved methods were made use of, it follows that little or no value can be attached to the alleged changes found by the observers of even a few years ago.

Erb is a firm believer in the essential identity of these two diseases. Speaking of the juvenile form of muscular atrophy he says * "there is a particular form of disease of the muscles which consists partly in hypertrophy with subsequent atrophy of the muscular fibres, partly in hyperplasia of the insterstitial connective tissue with more or less lipomatosis. Whether the changes in the muscular fibres or in the connective tissue is the primary event, or whether they are simultaneous appearances has not yet been definitely settled. There are no changes in either the peripheral or central nervous system. It is a very chronic and slowly progressive trouble. Clinically the disease is characterized by affecting in the upper part of the body, the pectoral, the trapezii, latississmi dorsi and other shoulder muscles, the muscles of the upper arm, while those of the forearm and hand escape. In the lower part of the body the muscles that suffer are those of the abdomen and the extensors of the back, the muscles of the thigh, calves, and the peroneal group. Cases of this disease in the past have been mostly described as ordinary cases of progressive muscular atrophy. A few as pseudo-hypertrophic muscular paralysis and hereditary muscular atrophy. If the disease appears in the earliest childhood, and if there is no lipomatosis it is what has been called hereditary muscular atrophy. If there is a high degree of lipomatosis, especially of the lower extremities it is what has been called pseudo-hypertrophic muscular paralysis. These three, hitherto separately named affections, are in reality one and the same disease. It is quite a distinct disease from the spinal form of progressive muscular atrophy." It follows therefore, according to Erb, that there are two distinct forms of progessive muscular atrophy—a neuropathic form and a myopathic form. In the patient whose case we examined into last week, we had a good example of the neuropathic or spinal form. The patient before you now is a good example of the myopathic form. For the former or neuropathic form of the disease Erb proposes the name "*Amyotrophia Spinalis Progressiva*," while for the latter or myopathic variety of the disease he suggests the name "*Dystrophia Muscularis Progressiva.*"

TREATMENT.—Before this patient came under the care of Dr. Wilkins, the atrophy had made such progress, that it was hopeless to expect benefit from any form of treatment. Where the disease is however seen early, there is fair grounds for hoping that in a small number of cases, arrest of it or even recovery may follow well directed treatment. As already mentioned, this form of muscular atrophy is more amenable to treatment than the spinal variety. There are very good grounds for believing that both forms would not be so fatal if more systematic and scientific attempts were made in their treatment. Physicians, as a rule, when they diagnose a case of muscular atrophy, pronounce it both "interesting" and "incurable." Seldom is even the attempt made to prevent the further progress of the degeneration. In the present state of the therapeutics of this subject, it is not possible in the very great majority of cases to prevent the progress of the disease. The few cases that have yielded to treatment are a sufficient proof that in the near future we will be much better able to combat this degenerative process. I would strongly advise you in all cases of progressive muscular atrophy, but especially in that form of the disease under consideration, to make persistent efforts to cure. The only therapeutic means of any promise is

* Erb: Ueber d. juvenile form d. progressiven Muskelatrophie u. ihre Beziehungen zur sogen. Pseudo-hypertrophie d. Muskeln-Deutsches Arch. f. Klin. Med. xxxiv. 5 u. 6 p. 467.

electricity, especially galvanism. The galvanization of the atrophic muscular groups should be performed very gently, otherwise the process may be quickened in place of retarded. It should be continued until it is quite clear that it is useless. Should it be of no effect, faradization of the affected muscles, or even general faradization should be resorted to.

EPIDEMIC CEREBRO-SPINAL MENINGITIS*

BY A. WORTHINGTON, M.D., CLINTON, ONT.

I desire to present for your consideration a brief history of an outbreak of epidemic cerebro-spinal meningitis, which took place in the county of Huron early in the year 1872, and in connection therewith some ideas in reference to its treatment. The outbreak occurred at Clinton about the latter part of December, 1871, or the 1st of January, 1872, and was termed in the neighboring towns, "the Clinton malady." It continued in and around Clinton the remaining part of the winter, and the greater part of the following summer. In other parts of the county, cases continued to occur as late as the fall of 1873. The localities visited by this epidemic appeared to be confined principally to the vicinity of streams and lowlands, carrying with it the idea that the specific poison might possibly emanate from that source. The idea was suggested to me by a Toronto medical friend. Mr. John Netton Radcliffe has written more fully on this subject than any other author to which I have had access. He says, "Locality and soil do not exercise any manifest influence over the disease. It has been observed on low grounds, high lands, and on soils of the most varied character indifferently." Sanitary regulations and precautions appeared to have very little influence in this epidemic. The rich and poor were visited alike—the well-fed, well-housed, well-clothed suffered equally with the poorly-fed, housed and clothed. According to Mr. Radcliffe the reverse obtained in certain outbreaks, as that on the Lower Vistula, where the "prosperous classes suffered to a much less extent from the malady than the poor and miserable, who were subjected to privations, and much foulness of persons, dwellings and atmosphere." Mr. Radcliffe again says, "There is not any constant or common relationship between any insanitary state, and the appearance of the disease. Neither foulness of house and its surroundings, nor the atmosphere, whether from putrid emanations, or from over-crowding, nor impurity of any other kind, has any determinate relation with epidemic cerebro-spinal meningitis." Since the discoveries of Pasteur, Koch and others, it appears quite probable that a germ cause may yet be found for the disease, when some future outbreak provides the opportunity. The attack in many cases was exceedingly violent, causing death in from 24 to 48 hours, death being always preceded by profound coma. Mild cases, which were easily controlled, and terminating in convalescence, were quite numerous. Two cases were observed, which ran 36 and 68 days respectively, ending fatally. The disease was almost invariably ushered in with rigors, more or less severe, and accompanied or followed by pain in the head, sometimes of such a terrific character that the patient continued to cry out until unconsciousness relieved him of sensation. Pain along the spine was noticed as being very severe in only a few cases, but was nearly a constant symptom. Retraction of the head was rarely absent—in some very severe, in others very little. Vomiting was among the early symptoms, but ceased when the disease was fully established. Delirium was a constant attendant in all severe cases; arterial tension was invariably deficient, the pulse being usually abnormally slow, but often frequent towards the end in fatal cases. The temperature in all the cases observed was above normal with one exception. Respiration was irregular; in bad cases, "sighing and labored" according to severity. The treatment, if commenced early, seemed more likely to be satisfactory than if begun later on. Observation has led me to think that epidemic cerebro-spinal meningitis is not necessarily so fatal as is generally supposed. I have, however, never seen any case recover where the patient had passed into a state of stupor for over two to three hours.

In the treatment of epidemic cerebro-spinal meningitis, the removal of all the hair from the head as closely as possible—even shaved—appears to me to be the first essential in all cases of severity. The application of cold to the head is cer-

* Read before the Ontario Medical Association, June, 1884.

tainly the next (except in cases of collapse or approaching collapse), for without this application, the case may be left to take care of itself, as it certainly will, but it is needful to use the cold cautiously, guarding against the too sedative effect on the already weakened heart, at the same time using sufficient to control and reduce the engorged condition of the vessels of the brain. Blisters to the back of the neck were of great benefit, probably by producing exaggerated circulation near the brain, also along the spine in case of severe pain and spasm of the spinal muscles. Cold was applied in these cases at the same time as the blisters. It appeared to me to be of the utmost importance that cases of this disease should be seen at the earliest possible moment. Treatment delayed beyond two to three hours after the supervention of stupor, appeared to be useless, as I have not known any case to recover under such conditions. Of medicines, only two were used—aconite and morphia—others might be equally good, but I had not tried them. The two named I had tried and knew what they would do. Aconite controlled the circulation and reduced the temperature, when necessary; morphia seemed to have a marked effect—under its influence the patient became more quiet and got absolute rest; *it appeared to do more, to have a curative effect.* In illustration of this idea, I may mention the case of the housekeeper of Mr. M——, farmer, in the township of Tuckersmith, who had been suffering for several days with spasms of the muscles of the neck and back to that degree, that during the spasms she rested on her head and heels, her back being raised several inches from the bed, she being unconscious while the spasm lasted. The relief, when the spasm was over, was very little, as the retraction of the head was constant and very distressing, and drawn back as much as it could be apparently. When taking nourishment, she could only put some in her mouth, and then push it along down the œsophagus with the thumb and fingers, on account of the muscles of deglutition being stretched to that degree that she was unable to use them. These spasms occurred every 15 or 20 minutes, and lasted two or three. She also had cystitis. A solution of morph. sulph. gr. i, to ℥i. of water), was prescribed, a teaspoonful to be given every third hour as long as needed. I saw her first on the 18th May, 1872, and on my second visit on the 21st, she was quite free from spasms and evidently convalescing. So beneficial was morphia in that terrible disease, that the thought has occurred to me that it *might, like quinine in ague,* yet be found to be a germicide. In sporadic cases I have always pursued the same course of treatment, except, perhaps, in using less morphia, with the same result. I have selected the following four cases, as each was a little different from the other.

CASE 1.—S. S——, æt. 28, cooper, was attacked on the evening of the 23rd March, 1872. I saw him about 8 p.m. Pulse 68, temp. 99, resp. normal; said he felt very sick. I prescribed a febrifuge, and directed a mustard and water foot bath, and to go to bed. About 1 a.m. I was sent for, and found him in a state of stupor, quite unconscious, moaning, and very restless. On enquiry, I was told that in about half an hour after I had left the previous evening, he was seized with a severe chill, which lasted nearly an hour, and during the chill severe pain in the head came on, and so sudden and terrific was it, that his first exclamation was, "Oh! my head!" The pain continued to increase till about 12, when he became unconscious. His pulse was slow, labored and feeble, and his face, arms, hands, body, legs and feet, all were cold, and he was so restless that he could only be kept in one place a few minutes, when he would attempt to rise, perhaps stagger and fall unless held. No heat could be detected in his head, and he uttered no cry, but moaned continuously. It was not easy to know what to do for him. I, however, had his legs from the knees to the ankles, covered with plasters of mustard, and a heated quilt wrapped closely around him, then bottles of hot water and heated bricks kept as closely around him as it was possible to do in his restless condition, and a large blister placed on the back of his neck. As far as possible this course was followed till about 7 a.m., when reaction appeared to be slowly taking place. His movements now became more natural, and he seemed somewhat conscious that there was something wrong with his legs, as he tried to get at them, when he suddenly exclaimed, "Oh! my head!" As he merged towards consciousness, he complained so piteously of his head, that I bled him to about 4 oz., which seemed to ease the pain. I had previously cut the hair from his head, and now began

to apply cold water moderately. His temperature never rose above 101½, and his pulse was unnaturally slow, and very compressible, ranging from 60 to 80. Before night his reason had returned. He now complained of pain along the spine (rachialgia) very much, and there was considerable retraction of the head. The spinal pain and tenderness were treated by blistering and cold. On the third day he said he felt sufficiently strong, and was sent by train to Goderich, where Dr. McLean attended him some three or four weeks before he entirely recovered.

CASE 2.—H. S——, æt. 27, labourer, got intoxicated, and lay out over night, June 30th, 1872. In the morning he felt chilly and had a bad headache, and vomited several times. To relieve his head he put a piece of ice in his hat, and lay down upon the ground in the sun. The pain had increased so much by noon that his mind began to wander and I was sent for. I found him lying on the far side of the bed and he appeared to be in a high fever as his face was very red. I asked him if he could get over near me where I could examine him, and I should say that it took him five minutes to accomplish the task. He afterwards told me that he remembered when I went into the room, but nothing after. Pulse 113, temp. 103½F., resp. hurried. He remained delirious for about a week, and during that time there was pretty constant retraction of the head. I had the hair closely cut from his head, and bathed with water in which plenty of ice floated; the first application seemed to produce a shock, but after a few minutes he did not appear to notice it. A blister was applied to the back of the neck and the following prescription given:

℞ Morph. sulph. grs. ii.
Ext. aconiti. fl. m. x.
Aqua ℥iv.—M.
Sig.—A teaspoonful every two hours.

His diet was principally milk, no solid food being allowed. The temperature fell in a few hours to 101½ and did not rise above that again, but came down gradually to, and below normal. The aconite was discontinued after his pulse and temperature were well under control. The morphia was continued till reason returned, then changed to quinine and generous diet.

CASE 3.—Mrs. F., æt. 33, was taken down April 24th, 1872. She had been for several weeks taking care of her children, who one after the other had taken the disease in a mild form and lastly her husband, who was just recovering, when the attack came, and but for her exhausted condition would probably have been mild. A chill—not very severe—was the first instalment, followed by vomiting, confusion of intellect and delirium. The pulse from the beginning was feeble and very compressible, ranging from 65 to 110 with a marked want of arterial tension. The temperature ranged from 100 3-5 to 103 1-5, being higher in the early stages. Respiration was variable, sometimes hurried, then sighing and irregular. The vomiting ceased on the appearance of delirium. The bowels required but little attention during the attack. On the third day a thick mottled eruption was noticed, purpuric in character, the size being from a pin's head to that of a split pea—the large ones being of a dark purple while the smaller ones were of a reddish cast. Large and small were thoroughly intermingled. Pain in the head, neck and along the cord, especially in the dorsal region, was constant. In a later stage cystitis made its appearance and caused much trouble and anxiety. Still later she suddenly became blind and remained so for about twenty-four hours—this I attributed to nervous exhaustion. She had been taking quinine every two hours, but by some oversight of the nurse it was omitted for about twelve hours during which time she lost her sight. The treatment from the first had to be supporting; aconite was given very cautiously and for a short time only. Morphia was continued through to the end. Her hair was cut off except a little on the front of the head, and cold kept constantly applied. Her neck and the upper part of the spine were repeatedly blistered, and cold applied as constantly as possible. Quinine was given early and continued until she was able to be about the house. Paralysis of the right arm remained for about three months, when sensation and motion were gradually restored. Duration of attack was 50 days.

Mrs. H. B——, æt. 26, was confined on the 25th April, 1872. Prior to confinement there appeared to be strong evidence of albuminuria, and my suspicions were fully confirmed on making the usual test. Her accouchement passed without trouble, and the kidneys gradually resumed their proper functions. Her progress was satisfactory up to 3rd May, when symptoms of some other

trouble appeared, but what it was I could not tell. There was a slight chill and slight reaction, pain in the head and back, but not severe. There was no vomiting, retraction, nor eruption. Pulse 92, temp. 100½, resp. seemed a little hurried, no abdominal tenderness, the kidneys were secreting the proper quantity of urine, and the albumen had nearly disappeared. There was no puffiness of the face, nor anasarca. The lochia had given no trouble. The pain in the head continued much the same, and on the 5th her mind began to wander occasionally, the pulse became more frequent and feeble, but the temperature did not vary much till towards the end, when it fell to below normal. No lesion of the heart or lungs could be discovered, and I could arrive at no other conclusion than that the poison of the then prevailing epidemic had secured a permanent footing in her system. She gradually sank and died on the 20th May, 25 days from her accouchement. Morphia was given and her neck blistered; tonics and stimulants and the best of nourishment were provided. No cold was used in this case.

REMARKS—The remarkable features in case No. 1 were the severity of the attack, the approaching collapse, and the rapid manner in which he rallied from what appeared to be a hopeless condition. He had uttered no sound but moaning during the five or six hours I was with him, until the exclamation Oh! my head! I confess I am at a loss to explain the rapid changes which took place in this case. In case No. 2 there was the curious fact that the nerves of motion were nearly paralyzed, as it took the patient fully five minutes to move from one side of the bed to the other, but after his hair had been removed, and the ice water applied for some time, he recovered the use of his limbs very fully, for in his delirium, and when his brother was off his guard, he sprang and seized his brother by the throat and was very near strangling him. Case No. 3 was in several points a remarkable one: first, on account of the severity of the attack, which would probably have been mild but for her exhausted condition at the time. Second, the mottled appearance and abundance of the eruption which lay beneath the cuticle. Third, the supervention of cystitis, which helped to complicate the difficulty; fourth, loss of vision, and fifth, paralysis of the right arm. I have placed Case No, 4 in the list of those cases which were certainly epidemic spinal disease, because I could find no reason to place it anywhere else. The insidious character of the attack would seem to favor the idea that a specific deadly poison had entered the system probably through the same channels which we now charge germ poison with entering to produce puerperal peritonitis.

TWO CASES OF STRANGULATED FEMORAL HERNIA.

BY J. E. BROUSE, M.D., BROCKVILLE, ONT.

CASE 1.—May 13th, 1882, I was sent for to see Mrs M.——, in consultation with Dr. Lane, of Mallorytown, Ont. Her son, who came for me, stated that she had a lump in left groin, that there had been no passage through the bowels for some days past, and that there was frequent vomiting of fæcal matter. On arriving, found patient to be a somewhat stout, fresh, bright-looking lady aged 58. She was the mother of a large family, and had always enjoyed good health. Pulse 100, firm, not very compressible, but regular; temp. 101½. She said she had been ruptured for several years, but had not worn a truss, as the tumor was small, gave no trouble, and was easily reducible. Two days previous, however, while lifting, she experienced pain in the part and felt a sickening sensation, and on examining the swelling, found it to be larger than before. Dr. Lane was called in. He had given opium and tried taxis as fully as he dared, but without success. I had her placed on a well cushioned table, and, while under chloroform, had lower extremities elevated and flexed, and endeavored to effect reduction, but was also unsuccessful. The tumor was the size of an ordinary egg, and quite painful. The abdomen was tympanitic. While Dr. Lane continued the anæsthetic, I proceeded to operate, by an incision 2½ inches long in the axis of the tumor. A thick layer of fat necessitated cutting deeply before reaching the sac, which was much inflamed and very dark. After dividing the stricture at the upper and inner angle, found adhesive bands so firmly formed, that, although I separated them as freely as I could, it was impossible to return the sac. It was accordingly opened on a director, exposing a very dark, inflamed knuckle of intes-

* Read before the Ontario Medical Association, June, 1884.

tine, which passed readily into the peritoneal cavity. Three sutures, embracing the entire thickness, including the peritoneum, were passed, and dressings of carbolized lint and an oakum pad applied. A hypodermic of morphia was given, and patient placed in bed. No bad symptoms whatever supervened. Flatus passed the second day, and the bowels were freely moved by an enema the fourth day. She made a speedy recovery and is now alive and well.

CASE 2.—Nov. 1st, 1882, was asked to visit Mrs. T——, a lady 67 years of age, who had been taken suddenly ill, Oct. 25th, a full week previous. For several years she had been in bad health and quite feeble, so as to be unable to do anything in the way of house work. Oct. 25th, when going out of the door she slipped, and at once felt sick and experienced pain in the left groin, but did not say anything about it to her sister or family. In a day or two the pain increased, and she began vomiting, the bowels being obstinately constipated. Her sister, to help her on satisfactorily, gave her salts and castor oil, even repeating the dose. I was not sent for until the lapse of seven days, notwithstanding that stercoraceous vomiting had been going on for five days. The woman was greatly exhausted and looked so badly that I almost feared attempting an operation. The tumor was not larger than a walnut, but very painful, and the skin red. Giving her a hypodermic of ¼ gr. morphia, and obtaining the assistance of Dr. Vaux, who gave the chloroform, I tried reduction without avail, and operated at once. The sac appeared almost gangrenous, being nearly black. Without attempting to return it, I slit it up, exposing a small knuckle of intestine, in nearly as bad a state as the sac itself, though saw no actual sloughing. I was in doubt as to the propriety of returning it to the abdomen, but knowing the very great recuperative powers of both the peritoneum and intestine, and believing that, in her exhausted state, an external opening would prove fatal, the bowel was replaced and the wound closed. On Nov. 3rd, flatus passed, and the next day a copious motion of the bowels, which continued daily till her death, Nov. 8th. All tenderness over the abdomen passed away, and all tympanitis, but the nausea and vomiting continued in spite of every effort, and she died of exhaustion the 8th day after the operation.

These cases, especially the second, show the wonderful recuperative powers of the intestinal and peritoneal tissues, and I have no doubt that had Case 2 not been such a feeble person, with strength exhausted by stercoraceous vomiting before, and chloroform vomiting after operating, she would have recovered, the operation itself being a success.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—I am pleased at the position you assume towards some of the changes proposed by the Ontario Medical Council. Changes made by that body in former times were so frequent that one would need to have the minutes of their proceedings always at hand to assure himself of the legality of his position in almost any given case. It was hoped that the present Council would amend all that, and to a great extent they have done so, and it is therefore much to be regretted that the change of which you very properly disapprove, namely, the compelling of graduates in Arts to pursue a four years' course in medicine, has been made. Our profession is certainly not over-crowded with men of scholarly attainments, and we have always felt that every inducement compatible with a thorough medical course, should be held out to young men about to enter the medical profession, to encourage them to graduate in Arts before commencing their professional studies.

To place a gentleman who has passed through an Arts' course, and taken the degree of B.A., on a par in the matter of study with one who has just quitted the farm or the workshop, is certainly not in accordance with the dictates of experience. Sixteen years' teaching has convinced me that on an average the Bachelor of Arts will acquire as much professional knowledge in three years as one who has not had such a course of training will in four; and besides this, we all know that after the M.D. has been obtained, the man who has also had the training of an Arts' course is much better qualified to fulfil many of the duties which in after life devolve upon the active and respected medical man. I take the average as a rule, and do not ignore exceptions, which are conceded to be the accompaniment of all rules. Apropos of this matter I may

quote a pithy little extract from the *Queen's College Journal* for June—

"It is a significant fact that the Medicals who succeeded this year in taking University prizes are graduates in Arts. The prizes be it noted, were given for essays upon subjects in connection with the medical course. Theorists may maintain that a physician does not require an Arts education, but it is facts and not theories that for the sober-minded are trumpet-tongued. While it would be probably too much to require that every M.D. should be a B.A., as it would be to require that every Reverend should be a B.A., yet as the requirement is being at least generally fulfilled in the latter case, so it should be in the former. The spirit of the times is happily pointing in that direction. Queen's has begun to agitate for a higher standard for matriculation in medicine."

We hope, however, that with the object in view of promoting a higher standard of general education in our profession, such an amendment as the one under discussion will never become a permanent law, unless as a compensating rider they make it compulsory on every medical student to pass a matriculation examination equivalent to that for the degree of B.A.; but this would be asking too much, and hence we ask for a continuance of the old *regime.*

Another change we object to is the imposition of an annual tax of $5, instead of $1, upon every registered practitioner while we receive no corresponding value. Raising money in this manner for the purpose of stocking the rooms in which the Medical Council meet with a library and museum, does certainly not commend itself to the profession at large, inasmuch as our representatives are sent to Toronto for the purpose of legislating in behalf of our professional interests, and not for the purpose of refreshing their minds by perusing the tomes of a library and examining the specimens in a museum. We have been waiting patiently year after year to see some legislation that would bring under control the manufacture and sale of the many nostrums that flood our land; that would restrict or prohibit the misleading advertisements of shameless adventurers; that would enforce a proper code of ethics amongst qualified practitioners, and provide for the disciplining of those who habitually transgress it; to restrain druggists from their almost universal custom of prescribing for patients, etc. etc.; but we have hitherto waited in vain. Until our Council can show us some practical work, beyond the modifying of curricula, and the transferring of the subjects of medical study from one part of the course to another, and back again, I for one most emphatically protest against paying any more than we pay at the present time. Let them turn their attention to clearing away some of the impostures and annoyances to which both the laity and the profession are subjected, and then we will hail the labors of the Medical Council with gladness and bid them God-speed in their laudable efforts.

Yours truly,

THOS. R. DUPUIS.

Kingston, July, 1884.

Reports of Societies.

ONTARIO BOARD OF HEALTH.

The third quarterly meeting of the Provincial Board of Health was held in Toronto on the 31st of July, Dr. C. W. Covernton in the chair. The fore part of the day was taken up with matters of routine, the secretary's report of work done, etc. Replies were read to the circulars sent out to local boards, some of which showed considerable interest in sanitary matters, while others were the reverse of what should be expected. Pamphlets on cholera were distributed in large numbers. Correspondence had passed between the Board and the Dominion Government regarding the precautions which were being taken by the quarantine officers at ports of entry to prevent the introduction of infectious diseases. The replies, though courteous enough, were far from satisfactory.

The chairman read a report on epidemics, in which he alluded to the absorptive powers of milk, and the dangers arising therefrom. He gave instances of outbreaks of typhoid fever and other infectious diseases which had been directly traceable to this source.

The secretary was instructed to communicate with the railway authorities, recommending that they provide dry earth closets on all cars.

The second day's session began at half-past ten a.m. The secretary read a letter from Dr. Brown, of Galt, stating that the manufactories on the east side of the Grand river were making offensive deposits in that river, and stating that he had taken steps to force the owners to stop the nuisance. He wished to know if the Board would support him in this action.

On motion of Dr. Cassidy, a Committee was appointed to enquire into the evils of baby farming, and suggest a remedy.

The Board then went into Committee of the Whole to consider the report which was to be handed to the Lieutenant-Governor concerning the precautions which, in the opinion of the Board, should be taken in case cholera should break out

here. The following is the substance of the regulations which were recommended :

As soon as danger has become imminent, the Board shall ask for a grant to be set apart by the Government sufficient to enable the Board to pay a medical executive officer in each town in the Province, and to meet the expenses incurred in taking precautions against the spread of the epidemic. These medical health officers will be executive officers of the Board ; and where it is found possible, the officer of the Local Board of Health shall be chosen for the position. He shall report to and act in accordance with the instructions of the Board.

On the approach of the first case of cholera the medical health officer shall at once remove it to the isolation hospital, and shall take every measure for the disinfection of linen and clothing worn by sufferers, and if necessary destroy them. He shall be careful to destroy any food which has begun to decay.

In regard to the quarantine stations which shall be provided by the local Boards of Health, all persons who may have been exposed to the infection shall be detained until such time as the period of incubation shall have elapsed, and shall be permitted to go only on being thoroughly disinfected by fumigation.

If any municipality be a port of entry from infected districts, the medical executive officer shall make a strict inspection of said vessel before any passengers, luggage, or freight from it be allowed to land ; and where any affected or exposed persons are found on board they shall be dealt with in the manner above indicated. And further all personal effects or other exposed luggage or freight shall be thoroughly disinfected before being landed.

Wherever cholera exists in any Province or State adjoining Ontario, from which railways enter the Province, the medical executive officer shall be given the full powers of a quarantine officer as far as can be exercised under the provisions of municipal or provincial laws. He shall examine all trains suspected of containing cholera, making thorough disinfection. The medical executive officer may by arrangement with the railways, board the trains when some miles outside the Province, in order to avoid unnecessary detention of trains.

Should cholera appear in this Province or in any Province or State adjoining this Province, the medical health authorities shall, under the direction of the Provincial Board of Health, carry out the recommendations contained in the pamphlet No. 14, issued by the Board.

Dr. Oldright then read a report on the prevalence of typhoid fever at the Kingston Insane Asylum. He had found the ventilation and drainage defective and the water tainted.

A letter was received from Mr. Prust, of Haliburton, complaining of the nuisance of sawdust deposits in the lake. The chairman and secretary will take steps to assist the local Board in abating the nuisance.

In the evening session, Dr. Yeomans presided in the absence of Dr. Covernton. Upon enquiry, it was found that many municipalities had not formed local Boards under the Act, and the secretary was instructed to notify the clerks of the municipalities, and that in case the law was not complied with, the Provincial Board would appoint members of the Local Board, as provided for in the Provincial Health Act.

The secretary was also instructed to inquire through the proper official channel what precautions the Dominion and other Provincial authorities were taking to prevent the introduction and spread of cholera and other zymotic diseases.

Dr. Cassidy and Dr. Bryce were appointed delegates to the Sanitary Conference at Washington, and Dr. Covernton and Dr. Oldright to the British Association for the Advancement of Science, and the Canadian Sanitary Association at Montreal. The chairman will appoint a deputation, including himself, to the meeting of the American Public Health Association at St. Louis in October.

THE NEW BRUNSWICK MEDICAL SOCIETY.

The fourth annual meeting of the New Brunswick Medical Society was held in St. John, on the 17th and 18th of July. The attendance was large, there being fully forty members present. Hon. Dr. Vail, the president, occupied the chair. Dr. Musgrove, in the absence of Dr. Duncan, was appointed secretary *pro tem.*

The president made a brief address, expressing his pleasure at seeing so many members present, and describing the objects for which the society was formed and the advantages of belonging to it.

A communication was read from the W. C. T. U. referring to the increase of intemperance, caused to a certain degree by the administration of alcoholic stimulants by physicians, and calling upon the society to unite with them in suppressing intemperance. The communication was filed.

Dr. F. A. Nevers, the treasurer, reported that after paying the bills there remained on hand $87.05.

The committee appointed to consider the feasibility of publishing a *Journal* reported in favor of the scheme, the publication to be entitled, *Medical and Surgical Journal* of the N. B. Medical Society. Messrs. J. & A. McMillan's offer to publish the work quarterly, 200 copies, twenty-four pages, without charge, on consideration that they receive the benefit of all advertising, was recommended for acceptance. The vote on its adoption stood 19 to 15. Drs. J. D. White, S. Z. Earle and J. T.

Steeves were appointed a committee to superintend the publication of the journal, and Dr. L. C. Allison was appointed editor.

The following officers of the society were elected: President, Dr. Thomas Walker; 1st Vice-President, Dr. E. M. Patterson; 2nd Vice-President, Dr. George Taylor; Secretary, Dr. T. W. Musgrove; Treasurer, Dr. D. E. Berryman; Cor.-Secretary, Dr. W. F. Coleman; Trustees, Drs. Coleman, D. E. Berryman, Daniel; Council, Drs. Steeves, Earle, Vail, Moore, Christie.

Dr. Grant, of Ottawa, who was present, was invited to a seat on the platform, and addressed the society. He alluded to the energy, activity and ability displayed by the profession in New Brunswick, and was pleased to see so large an attendance. He also referred, among other things, to the excellent summer resorts in this part of the Dominion, and concluded by wishing the society many years of success.

In the evening there was a very pleasant conversazione, at which a large number of ladies were present. Dr. Vail presided. A paper on Sanitary Science was read by Dr. Bayard. Music and short addresses by some of the medical gentlemen present, enlivened the proceedings. Refreshments were served during the evening.

SECOND DAY.

The society met at 10 a.m., Dr. Walker in the chair.

After routine, Dr. Gray read an excellent paper on "Uterine Fibroids," in which he gave a number of cases in his own experience. An interesting discussion followed.

Dr. Moore then read a paper on the treatment of "Hydrocele" by iodine and carbolic acid.

Dr. S. Z. Earle thought that these remedies would not effect a permanent cure. He related a case where the disease had returned after twenty-two years.

Dr. Harrison agreed with Dr. Earle. A similar instance had come under his notice.

Dr. Frank Nevers related a case in which he had used iodine, U. S. P. At first he did not think that his patient would rally, but subsequently he came round all right. In future he would be inclined to use carbolic acid.

Dr. McFarland read an interesting paper on "Conservative Surgery in Compound Fractures," and described the mode of treatment he adopted. One of his patients, whose leg had been badly mangled, was shown, and the limb examined.

Dr. Moore and others expressed satisfaction with the paper and hoped that it would lead medical men to be more careful in dealing with fractures.

Dr. James Christie said there were cases which terminate well, and there were other cases in which the patient dies. It was often a serious question, whether we should amputate or not. In the present case a good constitution had largely been the cause of the patient's recovery.

Dr. Nevers related a case in which the patient had died by endeavoring to save her limb.

Dr. Coleman stated that the mortality in amputation of the thigh was 63 per cent.

Dr. Coleman then read a carefully prepared paper on "Some Points in the Diagnosis and Treatment of Diseases of the Eye." In the discussion which followed, the paper was warmly commended, and regret was expressed at the rumor that Dr. Coleman intended to leave St. John.

Dr. James Christie read a paper on "Amputation after Recent Injury," citing a case or two in support of his contentions.

At the afternoon meeting Dr. Musgrove read a paper on "The Proper Use of Alcohol as a Medicine," taking strong ground against its use, except in the way arsenic, opium, or any other poison is used. In the discussion which followed, the usual view prevailed, that competent medical men were the best judges of when and how to prescribe alcohol. The medical profession is opposed to the use of alcohol except in case of absolute necessity.

Last, but not least, was an admirable paper on "The Germ Theory in Disease," by Dr. J. P. McInerney, of Portland. Drs. Barker, Coleman and Grant spoke in high terms of the paper.

The next annual meeting of the society will be held in Fredericton, and Drs. Brown, Currie, Coburn and Barker were appointed to make arrangements.

HURON MEDICAL ASSOCIATION.

The regular meeting of the Huron Medical Association was held in Clinton on the 8th July, Dr. Williams, president, in the chair.

Dr. Hyndman, of Exeter, presented a case of hemoptysis, recurring since the 7th May, quite frequently. The patient last fall had an attack of bronchitis from which he apparently recovered. On careful examination the normal respiratory murmur was heard, except at one point about two inches in diameter and about the same distance below the left clavicle. His general appearance is one of fairly good health. There can, however, be little doubt that he has incipient phthisis.

Dr. Elliott presented a boy four years of age, who had been attacked with inflammation of the left arm below the shoulder, resulting in an abscess. Another soon formed at the joint, from which a quantity of pus was evacuated. The head of the scapula was found carious and the entire epiphysis removed at different times. The result was recovery with partial anchylosis. A little mobility of the joint existed which would likely increase.

Dr. Campbell, of Seaforth, reported a case of Pott's curvature of the spine, in a lady of 59 years, in which entire recovery took place after seven plaster of Paris jackets had been used. He also reported a case of pleuro-pneumonia ending in empyema. Six pints of healthy pus were taken by aspiration, and fourteen days after eight pints of very fetid pus were removed by free incision, and the cavity washed out three or four times a day with carbolic lotion.

Dr. Worthington presented a case of rodent ulcer, situated at the outer angle of the left lower eyelid. The treatment advised was scraping with Volkman's spoon and cauterizing with chloride of zinc solution. He also presented a case of congenital defect of the spinal medulla, and probably of the left frontal lobe of the brain. The patient is six years of age, and cannot walk, but is making some effort to do so, and also to talk. When an infant he had no control over the motions of his head whatever. When attempting to walk he is bent very much forward and both arms extended. There is a want of co-ordination which in time seems likely to be overcome. He has perfect control of his passages.

Drs. Smith and Nichol are to prepare papers for the next meeting.

BATHURST AND RIDEAU MEDICAL ASSOCIATION.

The eleventh annual meeting of the Bathurst and Rideau Medical Association was held at Carleton Place, on the 9th of July. There was a large attendance of members present, Dr. Cranston, President, in the chair. The Secretary's minutes and Treasurer's report were read and adopted. The latter announced that as there were sufficient funds on hand no levy would be made this year upon the members.

The President, in his annual address, alluded to the work done in the Medical Council, referring particularly to the proposed changes in the Medical Act. A discussion followed, in which many took part; the increase of the annual fee was objected to, especially the payment of a life fee which, it was contended, would only encourage extravagance in the Council, and when the fund was exhausted, the practicing physicians would again have to contribute to support the Council.

Dr. R. H. Preston exhibited a case of disease of the ankle joint. The trouble was of several months duration, pain was now very severe, swelling slight, tenderness not very marked, movements of foot were not difficult. All usual remedies, both internal and external, had been tried; he proposed to drill for pus, suspecting an interroseous abscess of the tibia. Drs. Grant, Horsey & McEwan concurred in his views.

Dr. Grant, jr., read a paper on "The Pathology of Tubercle," exhibiting several slides of tuberculous and healthy tissue of various organs.

The Secretary read a paper from Dr. Malloch, of University College Hospital, London, reporting a case of "Hydatid Disease of the Liver," detailing operation and post mortem appearances.

The following officers were elected for the ensuing year: President, Dr. Cranston; 1st Vice-President, Dr. Preston, M.P.P.; 2nd Vice-President, Dr. Horsey; Treasurer, Dr. Hill; Secretary, Dr. Small.

The meeting then adjourned, to meet in Ottawa in January, 1885.

NOVA SCOTIA MEDICAL SOCIETY.

The annual meeting of the above named society was held in North Sydney, C.B., on the 9th and 10th of July, under the presidency of Dr. Somers, of Halifax. There was a good attendance of members. After routine, the President delivered an able and instructive address. The reports of the Standing Committees were then presented. The report on Medicine was prepared by Dr. Moore, of Kentville, and in the discussion that followed, the communicability of phthisis was chiefly taken up. It was decided to issue cards to the profession that a record may be had of all cases of this kind during the year.

The report on Surgery was presented by Dr. Stewart, in which he raised the question of antiseptic treatment of wounds, etc., upon which the President had also touched in his address. The report elicited considerable discussion.

In the afternoon, Dr. McGillvray presented the report on "Therapeutics," giving a succinct classification of recent popular remedies, showing that 97 in a list of nearly 300 had been more or less successfully adopted, while 190 had been rejected as useless. Dr. Angus, of Oxford, also reported for the same committee. The report on "Obstetrics" was presented by Dr. Page, in which he criticised the systems adopted by certain schools of practitioners.

The following gentlemen were elected members of the Provincial Medical Board under the new Medical Act: Drs. Somers, Wickwire, and J. F, Black, Halifax; Johnson, Sydney Mines; McIntosh, Antigonish; and Perrin, Yarmouth.

Dr. Tobin, of Halifax, read a paper on "The Modern Operation for Cataract Extraction," which was well received.

In the evening session a paper was read on "Medical Education in Nova Scotia" by Dr. Reid, Superintendent of the Insane Asylum.

On Thursday morning, Dr. J. W. McDonald read a paper on "Sanitation in regard to Diphtheria." In 1880 no less than 2,000 deaths occurred from this disease in Nova Scotia, but last year so great was the advance of the people in

sanitary knowledge, the death rate fell below 500. Dr. McDonald contended that the prevalence of diphtheria was entirely owing to the lack of sanitation. Quite an animated discussion followed in regard to the infectiousness of diphtheria. Dr. McKay followed with a paper on "Sanitary Legislation." He advocated the enforcement of our present sanitary laws, the establishment of a Department of Public Health in the Cabinet, and the appointment of an Inspector of Health for each County.

The following officers were elected for the ensuing year: President, Dr. H. B. McPherson; 1st Vice-President, Dr. John Stewart; 2nd Vice-President, Dr. T. R. Almon; and Secretary, Dr. J. W. McDonald. Dr. W. McK McLeod was placed on the Standing Committee on Medicine; Dr. Lewis Johnston on that of Surgery, and Dr. Wm. McKay on that of Obstetrics.

In the afternoon the visiting gentlemen enjoyed an excursion on the harbor, as the guests of the C. B. Medical Association.

The society met again in the evening. The question of the union of the associations of the Maritime Provinces came up, but its consideration was deferred. Dr. Stewart gave notice of his intention to move next year in regard to the matter of physical education in the public schools.

After the usual votes of thanks, the society adjourned to meet next year in Halifax. Much of the success of the present meeting was due to Dr. McPherson, upon whom devolved the local arrangements.

MICHIGAN STATE BOARD OF HEALTH.

Reported for the CANADA LANCET.

The regular quarterly meeting of the Board was held in Lansing, July 8, 1884.

The Secretary presented a report on four outbreaks of cheese-poisoning in Michigan, during May and June. All persons who ate of the cheese were taken sick, (in all about one hundred and sixty-four persons), with the same symptoms, i. e., pain and burning sensation in the stomach, intense vomiting and purging, feeble pulse, cold extremities, and tendency to collapse. All finally recovered. Specimens of the cheese were analyzed. Everything about the factory appeared to be scrupulously clean, and nothing in vats, cans, or surroundings offered any explanation of the cause of the poisoning. Analysis showed no arsenic, copper, lead, iron, or other mineral poisons. When the cheese was cut or broken, a whitish liquid oozed into the pores, and in the liquid microscopic organisms were detected. For more than one hundred years the attention of the scientific world has been drawn to the subject of cheese poisoning by repeated outbreaks from time to time. It has been variously ascribed to diseased milk, decomposition and the development of certain fatty acids, etc.; but it is not yet known what makes the cheese poison. The manufacturer said the cheese which produced the ill-results was all made between April 26 and May 26, 1884. It was made in the same manner and with the same care as other lots which had given no cause of complaint. Good cheese is only very slightly acid, and slowly reddens blue litmus paper. The poisonous cheese was intensely acid, instantly reddening blue litmus, when the paper was applied to the freshly cut surface. This test for poisonous cheese appears to be practicable. The blue litmus paper could be applied by any grocer to each freshly-cut cheese.

The Secretary reported an outbreak of small-pox in Ross Lake, introduced by a German immigrant. He said this outbreak was another illustration of how Michigan and the North-west suffer from the lack of a careful immigrant inspection service, such as was planned by the National Board of Health, and for a time carried on, but discontinued for want of an appropriation.

Owing to the spread of Asiatic cholera in Europe, and the liability of its introduction into this country at any time, it was decided to issue a circular to local Boards of Health on the prevention and restriction of cholera.

Other circulars on infectious diseases were ordered to be printed and distributed. A report of the work of the Secretary's office concluded the work of the Board.

Selected Articles.

CLINIC, BY ROBERTS BARTHOLOW, M. D.

CHRONIC ILEO-COLITIS.—The first case to be exhibited this morning, the child before you, was shown you some time ago, suffering with chronic ileo-colitis. The disease had been extremely persistent and severe, but under a properly regulated diet and the use of tincture of iodine and carbolic acid, the so-called carbolate of iodine—a half a drop of each being taken three times a day—there has been rapid improvement, and now the symptoms have disappeared, notwithstanding that the instructions in regard to the regulation of the diet have been imperfectly obeyed. You will remember that I insisted upon a change in the diet as of the first importance in the treatment of this case.

I hope that you will observe the character of the cough which the child has. It has frequently occurred ever since the existence of the ileo-colitis. Every time the child takes cold it has this hard, ringing cough which you now hear, and which is termed a "croupy cough." I have on several occasions insisted that this phrase is a misnomer. It is called croupy simply because it has the loud, ringing, metallic character which is as-

sociated with the cough of spasmodic croup. This is not the true croupy cough. The cough of exudative laryngitis is husky in addition to being ringing and metallic. The cough which this child presents is significant of laryngismus stridulus; that is, an affection of the larynx in which the muscles are thrown into a state of spasm. A child who during the day has been exposed to the cold, or who in the evening has eaten heartily of indigestible food, wakes up in the night with an attack of so-called croup. This is really an example of laryngismus stridulus, or spasm of the muscles of the larynx. In the case I have supposed there are two factors: the child takes cold, or it has an irritation of the gastro-intestinal mucous membrane. We can here apply with great certainty our physiological knowledge. The mechanism is very obvious. The pneumogastric nerve which supplies the mucous membrane of the fauces, and the gastro-intestinal mucous membrane in part, also has branches going to the larynx. This nerve is both motor and sensory in function. All the muscles of the larynx, with the exception of the crico-thyroid, are supplied by the inferior laryngeal nerve, while the superior laryngeal nerve is distributed to the mucous membrane and the crico-thyroid muscle. Now we have the terms of the problem. Irritation of the peripheral distribution of the pneumogastric nerve is referred to its motor branches, and the muscles of the larynx are thrown into a state of spasm. It would be a great mistake to confound this condition with true croup.

LARYNGISMUS STRIDULUS. — As laryngismus stridulus is merely a reflex spasm of the muscles of the larynx, those remedies which relieve spasm are the appropriate ones to use. In the present case we can prescribe a remedy which has a twofold effect; a remedy which benefits the intestinal inflammation, by acting through the nervous system, and which is also very effective in relieving the muscular spasm. This remedy, the bromide of potassium, will allay spasm of the muscles of the larynx, and it will also relieve certain kinds of irritation of the gastro-intestinal mucous membrane. In that disease commonly known as summer complaint bromide of potassium is one of our most efficient remedies. Why? Because it acts on the vascular supply of the mucous membrane, through the nervous apparatus, the semi-lunar ganglion and solar plexus. We have in this drug a remedy which fulfils all the indications of the present case. I direct five grains of bromide of potassium to be taken every three hours until the symptoms subside. The injunctions in regard to the diet must be repeated. When I last saw the child I carefully indicted the food which should be used. I now learn that the child has been given bread in considerable quantity, with the idea that bread, being the staff of life, can do no harm, and is always in place. In such cases as this bread is always out of place. It is unsuitable; because it is an eminently fermentable substance, and in the process of fermentation acids are produced which have an irritating effect on the inflamed mucous membrane.

CHLOROFORM IN TIC DOULEUREUX.—Here is another case which you have seen before, and I can now show you the result of treatment. It is a case of tic douleureux, *i. e.*, neuralgia of the superior maxillary branch or division of the fifth nerve. You will remember that I pointed out the various features of this case, indicated the painful points, and referred to the remedies most appropriate in its treatment, and I prescribed a remedy which has been found singularly efficient. There is no fact in therapeutics more striking than the curative results of a few drops of chloroform injected in the neighborhood of this division of the nerve, when it is the seat of neuralgia. In my experience the superior maxillary division of the fifth nerve is, above all the divisions of the nerve, most apt to be affected with neuralgia. Fortunately, it is this division of the nerve which is most easily acted upon.

Given a case of tic douleureux involving this nerve, how shall it be relieved? Simply lift the corner of the lip and insert the needle at the junction of the mucous membrane of the lip and that of the cavity of the mouth, and pass it up until its extremity comes in the neighborhood of the nerve, and inject from five to fifteen drops of chloroform or ether. As a rule, chloroform is less painful and more efficient than ether. In this case the pain at once subsided, and in the majority of cases the result, if not permanent, lasts for a considerable length of time. I have a patient in Boston, who comes to me twice a year to have this injection practised. In his case the neuralgia is probably due to intra-cranial disease. This measure has accomplished that which nothing else has done. The relief which he obtains is complete, and lasts never less than six months.

PARALYSIS FROM ENLARGED LYMPHATIC GLANDS.—This case has also been before you, and I am the more desirous of presenting it to you as there were some rather confused points in regard to the diagnosis. In this patient the parotid gland and the lympathic glands of the right side of the neck were greatly enlarged. This swelling of the glands was followed by an attack of hemiplegia. The mechanism which I maintained to be explanatory of this is the following: This mass of enlarged glands presses upon the cervical sympathetic and affects the intra-cranial blood supply. You will probably at once ask, "How is it that the paralysis involves the right side, for the enlarged glands are on the right side, and we know that the superior cervical ganglia controls the circulation of the same side of the brain?" We learn from the experiments of Bernard, which have frequently

been repeated, that when the cervical sympathetic is divided the corresponding side of the face and head becomes flushed, owing to the paralysis of the vessels. Suppose, however, that the nerve is merely irritated the unstriped muscles supplied by that nerve are thrown into a state of spasm, and this causes a diminution in the blood supply, the degree of which depends on the amount of spasm. In other words, irritation of the superior sympathetic produces anæmia of the brain. This does not explain the occurrence of the paralysis on the right side. It is a peculiarity of some cases that the impression is crossed. Why this should be has never been adequately explained. It is, however, a practical fact that the paralysis sometimes occurs on the same side as the lesion, and not on the opposite side.

The patient has been improving under the treatment, which consisted in the administration of one-half grain of sulphate of iron with $\frac{1}{10}$ of a grain of sulphate of strychnia three times a day. As you can see he has great difficulty in combining muscular movements. Looking at the face you observe that on the right side, the labio-nasal fold which passes from the corner of the mouth to the corner of the nose, is much less distinct that it is on the left side. This is always an important point. A very positive evidence of paresis of the seventh nerve is often afforded by that sign.

LUMBAGO.—A short time ago I presented several cases of lumbago, and dwelt on the differential diagnosis and treatment. Some of the cases were strictly of a rheumatic nature, while others were more of a neuralgic character. I enlarged upon the essential differences between these two forms of the disease, and pointed out how certain states of the system had much to do with the results of treatment.

In this case we had to deal with a rheumatic lumbago, and we put him on the use of salicylic acid. The pain has disappeared and the patient is nearly or altogether well. In those cases which are distinctly rheumatic, there is no question as to the efficiency of this remedy. I at the same time advised the external use of oil of wintergreen, which has been found of service in muscular rheumatism so situated as to be reached by topical applications. The result here has been eminently satisfactory.

INTERMITTENT FEVER.—This little girl has had attacks which the mother supposed to be sick headache. They have occurred periodically, but of late have been increasing in frequency. On inquiry we learn that the attacks began with chilly sensations and often with a decided chill. This was followed by violent fever and headache, and terminated in sweating. With the commencement of chilly sensations there appeared nausea, violent vomiting and distress of the stomach.

Looking at the phenomena presented by this history, there is no difficulty in making the diagnosis. The child lives in a malarial part of the city. The attacks begin winh a chill, followed by high fever, and terminate in sweating. The frequent recurrences of the seizures, and their persistence, indicates the existence of changes in the condition of the spleen and liver. In many examples of chronic malarial toxæmia the spleen is enlarged, but sometimes it is smaller that normal; in other words, in the most chronic cases the spleen is the seat of a chronic splenitis. The liver is also changed, being affected with pigment deposits and disorders of its circulation—the nutmeg liver. The paroxysms will recur as long as these modifications in the condition of the liver and spleen are allowed to continue.

The question which we have to consider is, how best to arrest the attacks. As the gastric disturbance is so great, attention to the diet will be necessary. In order to prevent the occurrence of the paroxysm, quinine must be administered, in anticipation of the seizure. We must do something more than this. The condition of the liver and spleen must be taken into consideration, for although there is no enlargement of the area of dulness proper to these organs, I have no doubt that they are the seat of the changes which characterize chronic malarial toxæmia. The spleen in these cases is not necessarily enlarged, and may, indeed, as already stated, be smaller than normal. The organ may be in the condition known to practical pathologists as the "fleshy spleen." This is a chronic alteration in which the trabeculæ are very much increased in amount, and the splenic pulp proportionately diminished. There is hypertrophy and hyperplasia of the connective tissue elements, and hence its fleshy appearance.

There are two remedies to influence the liver and spleen, which are especially valuable. The one is aqueous extract of ergot and the other is an iodide, especially iodide of ammonium. There is also a condition of anæmia for which remedies of the chalybeate group are indicated. The most appropriate one in the present instance is the arseniate of iron. The best results will be accomplished by giving quinine, to prevent the recurrent attacks, and the use of a pill, containing the following:—

R.	Extracti ergotæ,	℈ j	
	Ferri arseniatis,	gr. ss	
	Ammonii iodidi,	3 j.	M.

Ft. pil. No. xx.

SIG.—Two pills three times a day.

This prescription should be very persistently used. Under this plan of treatment, we will see the paroxysms subside and the marked improvement take place in the general state.

EXOPHTHALMIC GOITRE.—Before us is a case of exophthalmic goitre. One of the symptoms is

very manifest. You see the marked protrusions of the eyeballs. Let me first give the quarternary of symptoms in which this curious malady consists: first, protrusion of the eyes; second, enlargement and pulsation of the vessels of the neck; third, enlargement of the thyroid gland, and fourth, rapid action of the heart. Two of the symptoms give the disease its name—the exophthalmos and the enlarged thyroid.

Are all the symptoms present in this case? You see the condition of the eyes. I direct the patient to look downward; the eyelid does not follow the movements of the ball, and a considerable amount of the sclerotic is exposed. The cause of the protrusion has been much disputed. It has been attributed to œdematous swelling of the tissues back of the eye, and also to the action of the unstriped muscle of the orbital membrane. The latter is probably the chief cause.

Looking at the thyroid, it is found that although it is not much enlarged, the change is characteristic. It is the right side of the gland which is involved; the left side does not exhibit any enlargement. When only one side is affected, the rule is that it is the right side. The left side may subsequently be involved. In typical cases, the vessels of the thyroid also become enlarged, so that the gland pulsates like an aneurism and is often confounded with aneurism. The enlargement also presents the aneurismal whirr and thrill. This enlargement may be either temporary or permanent. At first the enlargement is merely due to the vessels; afterwards to the hyperplasia of the gland elements. In consequence of the lesion of the sympathetic, which is the seat of the trouble, the vessels dilate. The vessels of the neck in typical cases also become enlarged. We also find in this patient that the heart is affected. In typical cases where there is no lesion of the heart, the action of the heart is simply increased, the number of pulsations being increased, and the force of the pulsation much greater than normal. In old subjects, changes in the structure of the heart are apt to occur. In the present instance, when I apply a stethoscope over the heart, and especially over the mitral area, I hear a double murmur. This is not merely anæmic, but it is due to lesion of the valves. There are various changes which may take place in the heart, but no one of them can invariably be referred to this malady. As I have said, the heart is not necessarily the seat of any lesion in this disease, the only change being the increased number and the force of the pulsations. This might take place in one of two ways, either from irritation of the accelerator, or paralysis of the inhibitory apparatus. In this disease the lesion is in the accelerator nerves which arise from the sympathetic, and not in the pneumogastric nerve. Such is the mechanism and such the pathology of this affection.

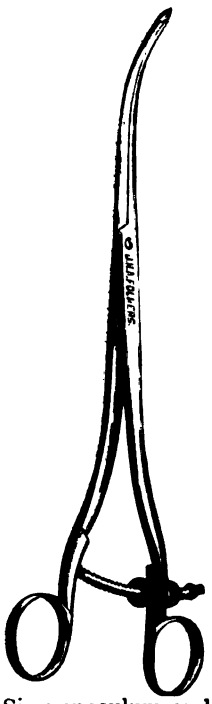
This being the nature of the case, what is the appropriate treatment? I have effected cures in several cases by persistent galvanization of the cervical sympathetic. This is done by placing one electrode in the fossa behind the angle of the jaw, and the other in the epigastrium. The continuous current should be passed for five, ten, or fifteen minutes. This at once diminishes the pulsation, and the protrusion of the eye is lessened. Of course, one application will not affect a cure; but I have no hesitation in asserting that in all uncomplicated cases, occurring in young subjects, a cure may be effected by the persistent use of the galvanic current.

In addition to this, remedies which modify the activity of the sympathetic system may be administered by the mouth. Digitalis has been much used, and has sometimes been of service. Ergot has also done good in many of these cases.

INSTRUMENT FOR OPENING PELVIC ABSCESSES.

In the *Pacific Med. Journal*, Clinton Cushing, M.D., Professor of Gynecology Cooper Medical College, describes a new instrument for opening pelvic abscesses through the roof of the vagina. The most frequent site for a pelvic abscess is either in Douglass' pouch behind the uterus or in the connective tissue of one or both of the broad ligaments on either side of the uterus. It may also occur in the connective tissue between the uterus and bladder, but this is quite rare. It may open into the vagina, the rectum, through the abdominal wall, into the bladder, or into the peritoneum; of the last mentioned, out of nineteen cases of pelvic abscess reported by Savage, of London, three terminated fatally in this way, and out of three cases opening into the rectum two proved fatal. The most favorable point for the escape of the pus is through the vagina. Between the uterus and bladder, there are no arteries of a size to make them of importance from a surgical point of view; but on either side the cervix, just above the junction of the vagina with the uterine neck, very important structures exist—no less important than the ureters and the uterine arteries. The uterine arteries which are as large as the radial, branch off the internal iliac on the sides of the pelvis and pass inward to the sides of the uterus just beneath the base of the broad ligaments and within a half inch of the roof of the vagina. The ureters pass over the brim of the pelvis beneath the pelvic peritoneum and run forward on either side the cervix to their position between the bladder and vagina. They cross the uterine artery about three-quarters of an inch laterally from the cervix, and both the nreter and artery are directly in the way if an at-

tempt is made to evacuate pus in broad ligament through the vaginal roof. The instrument—of which I herewith present a wood-cut one-third the size of the original—consists of two blades, which when closed form a trocar, and when introduced into an abscess direct, or along the side of an aspirator needle, the handles can be closed and the extremities separated so as to act as a dilator, and thus tear the connecting tissue sufficiently to furnish the most ample room for the escape of pus and the introduction of a drainage tube.



The manner of using it is simple. After making a digital examination and locating by the sense of touch the point in the vagina that you have determined to explore, turn the woman on her side in the Sims position, on a table before the window where the light is good. Introduce a Sims speculum and give it to an assistant to hold, and then seize the cervix with a small vulsellum to steady it. If the induration where the suspected pus is supposed to be presents no sense of fluctuation to the finger, pass a slender aspirator needle into the mass by means of a pair of strong dressing forceps and determine whether pus is present; if so, now make a slight incision alongside the needle and then introduce the trocar-pointed dilator by the side of the aspirator needle directly into the cavity of the abscess and close the handles before withdrawing it, leaving a large patulous opening into which the finger can be introduced, and of a character that does not tend to heal readily, admitting also of the easy introduction of a drainage tube. If fluctuation can be made out, the use of the aspirator is unnecessary. The advantage of this instrument over a knife is, that the danger of injuring the ureter or artery is reduced to a minimum; and the advantage over a trocar, is that of being able to make a large and free opening before withdrawing it, and with no additional risk. Doubtless the possession of this instrument with a knowledge of its use would give many men the courage to open and cure pelvic abscesses, that otherwise would allow them to go on to a bad ending. One of the difficulties attending the treatment of pelvic abscesses by openings through the vaginal roof is the inability to prevent the closure of the opening before the pus cavity has become entirely closed and healed, thus leading to a re-accumulation of matter. In order to meet this indication, I have devised a self-retaining drainage tube that has proved most satisfactory in my hands. The tube is made by taking a piece of rubber tubing of pure gum, the size of a lead pencil, and cutting off a section three-quarters of an inch long, in which an opening is made at its centre, at one side, equal to the diameter of the piece of tubing. This is now fastened transversely across the end of the longer piece of tubing with silver wire. It is easily introduced by means of a pair of long-handled dressing forceps, and when in place will be retained without difficulty, unless considerable force is made to withdraw it. Through this tube the cavity of the abscess can be easily washed out if needed, and it can be left in as long as any purulent matter escapes.

TAIT'S OVARIOTOMIES.

A correspondent in the St. Louis *Courier of Medicine* gives the following: The other day I asked Dr. Savage to what he attributed his and Mr. Tait's success—for they are very similar in their methods, and have much the same results—and he replied: "It can all be summed up in three words, 1st, cleanliness; 2nd, dryness, and 3rd, dexterity." To which I would add "carefulness."

The first, "cleanliness," brings up the question of antiseptics, which can be disposed of in a word, neither of them uses them. I may have something to say on this subject in a future letter, but, from what I have already seen, I must say that my confidence in Listerism has been very much shaken. Tait uses nothing but pure water, but Dr. Savage does use a little carbolic acid in the water in which his instruments are placed. The instruments and sponges are, of course, scrupulously cleaned, and plenty of water is used from beginning to end, but that is all the antiseptic that is used. There is no oiled silk or anything of the kind placed over the abdomen, but the parts are sponged thoroughly clean before operating.

There are only four persons who take part in the operation, the operator, his assistant, and two nurses to manage the sponges. The nurses have to redress before coming from the other patients, and in fact everything is done that can possibly be done to insure perfect cleanliness. If there are any visitors present, they are required to sign a certificate to the effect that they have not attended any post mortem examinations or contagious diseases for six days.

Before the peritoneum is opened, the external bleeding is arrested with Koeberle's scissor-shaped artery forceps, which are left on until it is necessary to complete the operation, when, as a general thing, all the bleeding is stopped. Just as soon as the peritoneum is opened, sponges are inserted

ad libitum. I have seen as many as twenty sponges in the abdominal cavity at one time. Before closing the incision, dry sponges are put in and taken out until they finally come out dry and clean, so that Baker Brown's old rule, "don't sponge the peritoneum," has been replaced with the opposite, "sponge until perfectly dry."

Mr. Tait is renowned for his short incisions. As a rule he seldom makes an incision longer than an inch and a half in simple ovariotomies, or the removal of the appendages. With this small opening, barely large enough to admit his two fingers, he diagnoses the case, and generally completes the operation. From what I have seen, and judging from a discussion that has just taken place in the *Lancet*, I am led to believe that no one ever attempts to perform the operation with as small an opening as Lawson Tait. He is remarkably skillful with his fingers, not only in abdominal section, but in every other operation I have seen him perform.

Carefulness in little things has much to do with success. In every operation there are the same number of artery forceps (12), the same number of sponges (either 12 or 20.) When the operation is about completed, and the sutures ready to be tied, the nurses have to count the sponges, etc. This, of course, is absolutely necessary, for it is a very easy matter to leave a sponge in. Several times I have seen the operator search the abdominal cavity for some time before a sponge could be found, that was known to be there only from counting them. The anæsthetic used is bichloride of methylene.

His method of treating the pedicle is the intraperitoneal, after ligating with silk. He uses a peculiar double knot for tying the pedicle, which, for want of a better name, I would call the Tait knot. The advantages of this knot are that while the whole is compressed into one surface, it ties the pedicle in two halves, and at the same time these halves are equally well compressed, so that very great constricting force can be employed. To tie with this knot a long handled needle is threaded with the silk required and pushed through the centre of the pedicle. The needle is then withdrawn, and a loop left on the opposite side of the pedicle. Then the loop is drawn over the tumor or ovary, and one of the free ends drawn through it, so that one end is above and the other under the retracted loop. Both ends being seized they are drawn through the pedicle, till complete constriction is made. A simple hitch is then made and tightened, as in an ordinary ligature. The pedicle is then cut about a third of an inch from the ligature.

The intraperitoneal method of disposing of the pedicle was a long while in being adopted, but it has been the means of lessening the mortality at least fifteen per cent. There are times, however, when the clamp must still be used. But in all the operations I have seen, I have only seen the clamp used five times—four by Mr. Tait and once by Dr. Savage—the latter a Porro's operation, and the removal of a six month's child.

During the ten weeks I have been here, Mr. Tait has operated sixty-five times, with only one death. The fatal case was a cancer case, and the operation was a *dernier ressort;* the woman died in twelve hours. Thus, throwing out this case, which really ought to be thrown out, we have sixty-four consecutive cases in ten weeks without a death. When we think what was the rate of mortality only a few years ago, when we expected at least twenty out of every hundred to die, we may well rejoice at the results of the present methods.

RETAINED PLACENTA.

Dr. T. Parvin in a paper read before the Philadelphia Co. Medical Society, thus discusses the management of retained placenta:—As long as the placenta is wholly attached, hemorrhage is impossible; the placenta is still a living structure and one with the uterus; to tear it loose, to directly detach it from the uterus, opens the way for perilous hemorrhage. Not only this, but such artificial detachment is usually incomp ete, is liable to injure the uterine tissue, and the operator's hand may be the bearer of septic germs, or these may pass in with the air admitted during the manipulation, and find a congenial soil for their development in fragments of placenta, or blood-clots that are retained in the uterus. Therefore, unless hemorrhage demands immediate interference, the obstetrician refrains from passing his hand into the uterine cavity for the removal of attached placenta; a completely adherent placenta is not so dangerous as the intra-uterine use of the hand for its detachment. I believe, then, that armed expectation is wise in the latter case, only endeavoring, by suitable compression of the uterus with the hand acting through the abdominal wall, to determine or assist that retraction of the organ which is nature's method of separating the placenta. After the detachment of the placenta—a fact which is best learned by feeling a part of the organ with the finger passed into the mouth of the womb—we may, by friction and compression of the uterus, if needed, evoke uterine contractions which will cause its expulsion. Those who believe that the placenta presents its fœtal surface at the os uteri, urge the value of moderate and continuous traction upon the cord, thus assisting the moulding of the mass to the orifice through which it is to come. This conservative view as to the management of so-called retained placenta has been strongly presented by Siredey in his recent work upon puerperal diseases. The common expression, retention

of the placenta, means very different conditions, each requiring its appropriate treatment.

Dr. Parvin concludes with a study of a ruptured uterus. The uterus was ruptured in consequence of a shoulder presentation, a case which ended in death the eighth day after delivery. Yet, he said, I would fail in duty to my profession that has been so generous to me, if I did not make the case fully known. The patient was a well-formed multipara; she had been in labor nearly twelve hours when I first saw her, the left shoulder presenting. Ether was immediately given until she was thoroughly under its anesthetic effect; and then, without violence, nay, with great ease, I passed two fingers behind the right knee, brought the foot down, and turning and delivery were effected in a few minutes; the placenta followed almost immediately; the child, quite a large one, was dead. The patient came out from the anesthesia satisfactorily; her pulse was good; there was no complaint, no shock, no great hemorrhage. Yet that woman had a ruptured womb, the tear beginning at the os uteri on the right side, involving the cervix and the lower part of the body of the uterus, this condition being made known by the post-mortem. If it be thought I ought to have known this accident at the time of delivery, I can only say that like ignorance happened to Dubois, to Hervieux, to Tarnier, and others—the first revelation of the uterine rent being made at the post-mortem; these silent tears of the womb are, as Hervieux has suggested, probably more frequent than generally thought. No, my self-reproach is not in this, but in not having made myself, or by another, an examination during pregnancy, so that the abnormal presentation could have been corrected, if not then at least in early labor. But let this pass. The great practical lesson to be drawn from the accident is not only the importance of an early rectification of a mal-presentation, but also an appreciation of the danger of rupture of the uterus, and how this accident occurs. The drawing now shown gives the position occupied by the child, and also and especially gives the change in form and thickness of the two cavities of the uterus, which, as so admirably described by Bandl, are formed when nature is unable to overcome the obstacle to labor found in such case. The one cavity is formed by the body of the uterus, and its walls become thicker and stronger; the other by the cervix, and its walls grow thinner—become indeed so attenuated and weak that a very slight additional strain at some point; that strain may come from a uterine contraction, or solely from the introduction of the finger; and thus peril from action, peril from delay must be before the obstetrician's mind when called to a case of neglected shoulder presentation.

Of course had I seen this patient an hour or two earlier, the event might have been different. The pressure of the presenting part had been so severe that a slough of the vesico-vaginal wall occurred, and the patient, had she recovered, would have required an operation for the resulting urinary fistula. I have thought that possibly the uterine rent was in part the result of a slough also; but be this as it may, there was not the slightest indication given at the post-mortem that any hemorrhage in the abdominal cavity had taken place.

THE EASY APPLICATION OF THE FORCEPS.—One of the chief minor objections to the use of the forceps is the fuss and trouble necessary to place the patient, already much exhausted and worried, in the orthodox position close to the edge of the bed, and, when so placed, patients frequently complain of feeling unsafe, and as if in danger of falling.

Let the patient lie in the ordinary position on her side, and at a reasonable distance from the edge of the bed, then let the upper blade be introduced as a lower blade, and then passed posteriorly round the head of the child into its proper position as the upper blade. When this is accomplished, the lower blade may be introduced in the usual manner, and the two handles locked. No force must be used, but the handle of the forceps manipulated as gently as that of a catheter when being introduced into the male bladder. I have applied the forceps in this manner more than twenty times in the last three years without any difficulty, and without causing any injury to the head or face of the child.

In teaching the use of the forceps, I think too little is said as to the direction in which the force should be applied after the head has reached the perineum, and when it is considered wise or justifiable to terminate the labor with the help of the forceps. I believe the force should be applied anteriorly, in a curved direction, terminating in a line almost parallel with the abdomen of the patient; in fact, in the same direction in which one might imagine that the woman herself would pull if attempting self-delivery with the forceps. Were more attention paid to this point, I am convinced that many perinæa which are now lacerated would escape uninjured.—Dr. Cribb, *Brit. Med. Journal.*

REMEDIES FOR GONORRHŒA.—No 1. —℞. Liq. ferri. subsulphatis, gtt. xv.; aquæ font q. s., ℥ iv. No. 2.—℞. Hydrastin muriatis, ℈ j; glycerinæ puræ f. ℥ ss; aquæ font q. s. f. ℥ iv. Directions. —Wash out urethra well with warm water, then inject formula No. 1. Six hours after use No. 2 by injection. Four days is all I ask for cure. This treatment has never failed where I have given it. —*Therap. Gaz.*

THE sulpho-carbolate of sodium, in thirty-grain doses given after meals, is recommended in flatulent dyspepsia. Also in ten-grain doses for nausea and vomiting, particularly in pregnancy.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science Criticism and News.

☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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The LANCET *has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

THE SPREAD OF CHOLERA.

Considerable anxiety is felt by the public in regard to the probable appearance of cholera on this side the Atlantic. It is impossible to say how soon, or when it may reach our sea-coast, for in these days of rapid railway and steam communication the germs may be carried to very distant parts in an almost incredibly short space of time. But whatever opinions may be entertained regarding the spread of cholera, the duty of the civic authorities, boards of health and the general public is clear. It is not enough to spend a few hundred dollars in cleaning up the filth in back lanes and alleys, the most thorough inspection and disinfection must be enforced. If proper and timely precautions are taken there need be no dread of cholera. Its outbreak in Toulon was the result of gross carelessness, and its continued spread the result of the *most disgraceful unsanitary conditions.* Although the violence of the epidemic has considerably abated, the area is very much enlarged, it having spread into the interior of France and Italy. At last accounts an outbreak in Algiers was feared. Koch has given the following instructions regarding the methods of preventing the spread of cholera: 1. Avoid contact with cholera patients or clothes worn by them; 2. practise temperance in eating and drinking; 3. avoid food that comes from an infected locality—cook it well; 4. see that the drinking water is *pure*—boil it; 5. avoid large gatherings; 6. disinfect choleraic evacuations with carbolic acid; 7. vacate apartments of cholera patients six days; 8. wash the hands with soap and water and carbolic acid if they have been in contact with cholera patients or their clothing; 9. disinfect linen before sending to the laundry; 10. disinfect all clothing of patients before transportation. The best disinfectants for cholera are carbolic acid, corrosive sublimate, and the zinc and copper salts.

A singular circumstance is mentioned in connection with the cholera in Marseilles, viz., that the swallows migrated at the outbreak of the pestilence and have not yet returned.

There are no specifics in the treatment. As most cases are preceded by a painless diarrhœa, it is well to adopt early treatment, so as to check it in the outset. Hypodermic injections of morphine and the internal use of opium, aromatics and astringents will be found most serviceable. Stimulants should be used with great caution. Horner's mixture, which has been recommended by Hartshorne and Bartholow in the *rice water* stage, is as reliable as any of the numerous so-called specifics:

℞—Chloroform,
Tr. opii,
Spts. camph.,
Spts. am. aromat., *aa* ʒiss.
Creasot., gtt. iij.
Ol. cinnamom., gtt. viij.
Spts. vin. gall., ʒij.—M.

Sig.—Dissolve a teaspoonful in a wineglassful of ice-water, and give two teaspoonfuls every *five* minutes. The following is the treatment adopted at Toulon and Marseilles:—In the first stage, twenty drops of laudanum are given with three grammes of ether, and ice in the mouth, to stop the vomiting. In the second stage, from ten to fifteen grammes of acetate of ammonia, the same quantity of alcohol, and injections of morphia, are given. If the breathing is embarrassed, oxygen is inhaled and the limbs rubbed with turpentine; and the *Medical Record* gravely adds, "the third stage is the coffin."

SURGERY OF THE URINARY ORGANS.

Late English journals bring us a report of the first of a series of lectures to be delivered by Sir Henry Thompson on the surgery of the urinary organs. Perhaps no man, living or dead, was ever better qualified to speak on this branch of surgery.

With rare natural and acquired gifts he combines a varied experience, in his chosen specialty, extending over a third of a century. The skill and experience which have made his name famous in this branch of surgery, he now proposes to make an open book for the benefit of suffering humanity. Thus it ever is in the higher walks of medical and surgical knowledge. The light is not hidden under a bushel to serve a selfish purpose, but is rather so placed that all who look may see.

Sir Henry, in his preliminary remarks, stated, that he became a specialist not from deliberate choice but by the merest accident. When about entering on the practice of his profession the Council of the College of Surgeons offered for competition as the subject of a Jacksonion prize, the "Pathology and treatment of Stricture of the Urethra." To the accident of having obtained this award, and not long after another Jacksonian prize for an essay on the prostate, he attributes the shaping of a career which he had never marked out for himself.

The subject of the lecture before us is Stricture of the Urethra. Of all the diseases, coming within the range of surgery, to which the urinary organs are liable, stricture of the urethra is by far the most common. Its victims are numerous and are to be found in every locality. As the common method of treatment is only calculated to afford temporary relief, nothing but evil forebodings is in store for the unhappy sufferer. Year by year he grows worse, until worn out by suffering catheterization, bladder and kidney troubles, he at last succumbs. Most practitioners of any experience can recall several such cases. The smallest diminution in the urethral calibre in itself of no consequence or inconvenience, often sounds the death knell of our patient. A trouble so grave in its ultimate consequences should never be regarded as trivial and undeserving of the most careful attention. Incipient stricture too often goes by the name of "gravel," to be treated by diuretics, thus seeking to overcome obstruction by increased force which is absurd. Catheterization next follows, sometimes with a view to gradual dilatation, but more frequently for the purpose of affording temporary relief from retention. It is cheering to learn from such an eminent authority as Sir Henry Thompson that nearly all cases of stricture are more or less within the range of surgical control. We can do no more than touch upon a few of the more practical points discussed in this important lecture.

For a simple stricture or narrowing, *the history of which is recent*, nothing need be done beyond gradually restoring the calibre of the canal to its normal state by means of flexible bougies, and for this purpose the style of bougie called "olivaire," is the one recommended, to be followed in severe cases by polished steel dilators. By the use of these or other dilators, according to the fancy of the surgeon, we are assured the normal calibre of the canal may be maintained in a large number of cases for a long period. When the passage has been restored it should be maintained so by an occasional regular use of the bougie by the patient himself. Congenital, organic, as well as acquired narrowings of the external meatus, and near to it, will not yield to dilatation. An incision is necessary in such cases. Strictures also within three or four inches of the orifice do not benefit much by dilatation. In after life when all the tissues become more rigid, dilatation is less effective. But it sometimes happens that this rigidity is absent even in the aged, and hence dilatation should first be tried. A decided tendency to contract, at any period, despite treatment by dilatation, calls for internal urethrotomy without delay. Prompt action will save much suffering, avert perineal abscesses, fistulæ, and organic changes in the bladder, ureters and kidneys. To delay until symptoms of such troubles appear involves complicity in a course which irretrievably damages the patient's life.

How to ascertain the extent and situation of the stricture, before attempting to divide the tissues which constitute it is the next point discussed. For this purpose nothing is better in the majority of cases than a bougie just large enough to pass through the stricture. In exceptional cases it may be desirable to use a series of solid bulbous-ended instruments, of which the stem is slender. Next follows a description of the urethrotome used by the lecturer. The mode of operation is then minutely described. The instrument should be constructed so as to cut from behind forwards.

The question is next asked and answered, what are the results of internal urethrotomy in relation to the reappearance of stricture? It is not possible to promise immunity from return. Great stress is laid on the necessity of *complete incision* of the con-

tracted tissues. The rule is that sooner or later the stricture will return. But in the meantime the patient has been placed in a condition of health and comfort for several years, saving him the suffering and organic changes which threatened his existence. When the trouble returns division can again be resorted to. It is not a dangerous proceeding, necessarily occasioning hesitation on the part of the patient when his condition requires it. As in the case of stone, stricture is to be dealt with as often as the case demands. In this way the implication of vital organs is avoided, and the patient is permitted to live out his days in comparative comfort.

The risks of the operation are small. Sir Henry has operated on about 340 patients. The number of operations must have exceeded the number of patients by several hundreds. Of the 340 on whom the operation was performed, six only died, or less than two per cent. Three of the deaths were due to pyæmia; one to embolism; two to extravasation and exhaustion, one of the latter being unfit for operation.

Such is a brief summary of the views of one every way qualified to speak; and such are the results of his long and wide experience. The low rate of mortality will be a pleasant surprise to many. Every surgeon cannot hope for results so satisfactory, yet we are convinced their publication will go far to disarm fear, and give such a stimulus to this branch of surgery as will diminish the suffering and brighten the hopes of many a doomed victim.

BRITISH MEDICAL ASSOCIATION.

The fifty-second annual meeting of the British Medical Association was held in Belfast, beginning on the 29th of July, under the presidency of Dr. James Cuming. Additional interest was imparted to the proceedings by the presence of a number of distinguished foreigners both from Europe and America—Profs. Benedikt of Vienna, Zehender of Roostock, Cordes of Geneva, Drs. Pozzi and Dujardin-Beaumetz of Paris, Gayet of Lyons, Drummond of Rome, Grant Bey of Cairo, etc., from the continent; and Drs. Flint, Sayre, Jacobi, Billings, Moore, Jones and others from the United States. Drs. Geikie, Douglass, Graham and McFarlane were present from Canada. About six hundred members attended the meeting. The president's address was on "The General Character of Epidemics," in which he referred to the present epidemic of cholera, and urged due vigilance on the part of the profession and the government. The subject of micro-organisms and their relation to disease was also considered. On the following day Dr. Sayre gave a demonstration of the application of the plaster jacket in curvature of the spine. The address on medicine was delivered by Dr. Ord of London, who took for his subject "Some Perversions of Nutrition caused by the Nervous System." He alluded especially to muscular atrophy dependent upon articular disease—Charcot's disease, rheumatic arthritis, gonorrhœal rheumatism, etc. The address on surgery was delivered in the surgical section by Sir William McCormac, in which he reviewed the advances made in "Abdominal Surgery" during the past five years, relating his own experience in two successful cases of gastrostomy for malignant disease of the œsophagus, sixteen cases of the radical cure for hernia performed as a sequel to herniotomy, and one of excision of a large goître. His method of the radical cure of hernia was to excise the sac, and ligate the neck, suturing the ring. The address on obstetrics was delivered by Dr. George H. Kidd of Dublin, taking for his subject "Puerperal Fever." With regard to etiology, he claimed that it was due to either or both of two causes—traumatism or epidemic influences. The address on physiology, which was a most able and interesting one, was delivered by Prof. Redfern of Belfast, and was well received. He dwelt chiefly on the progress of physiological science and its influence in medicine and pathology.

The work of the sections was characterized with earnestness and energy. The social aspect of the meeting was as agreeable as it was varied. The citizens of Belfast spared no pains to make their visitors happy. Public and private entertainments took place every evening, and excursions were made on Saturday to the Giant's Causeway, Garron Tower, Newcastle and other places. Dr. W. T. Edwards was elected President for the ensuing year, and Cardiff, South Wales, chosen as the place of meeting in 1885.

Dr. Koch has been decorated by the French Government with the *Legion of Honor*, in recognition of his services in the French cholera district.

THE INTERNATIONAL MEDICAL CONGRESS.

The eighth session of the International Medical Congress was formally opened in Copenhagen on Sunday the 10th of August, by the president, Prof. Panum, of Copenhagen, in the presence of the King and Queen of Denmark, the Council of State, and the King and Queen of Greece. The attendance comprised about 1600 medical men of all nationalities, including about 100 English and 50 Americans. The *Medical Record*, of New York, with characteristic enterprise, gives a cable report of the proceedings, from which we glean the following. An address of welcome was delivered by the president, followed by a brilliant reply from Sir James Paget in behalf of Great Britain, Prof. Virchow in behalf of Germany, and Pasteur in behalf of France. A grand banquet was given in the evening. On Monday the work was inaugurated by the division of the Association into sections, sixteen in number. Prof. Pasteur delivered an address in the general session on "Micro-organism and Vaccination," in which he referred to the report of the French commission, stating that of twenty-three protected dogs bitten by rabid animals in June last, all remained healthy, while of seventeen unprotected animals similarly bitten, fifteen went mad. He emphasized the practice of inoculating dogs only, and said if they were protected the disease would die out. Very interesting addresses were also delivered by the chairmen of sections and many excellent papers read and discussed. On the third day Prof. Tommasi Crudeli, of Rome, read an address before the general session on "The Nature of Malaria," and the means of making malarial countries healthier. Many interesting and valuable papers were also read before the different sections, too numerous to mention. The fourth day was devoted to excursions, one of which included a visit to Elsinore, the assumed scene of Shakespeare's tragedy of Hamlet.

It is expected that the next session of the Congress will be held in America, the invitation on behalf of the American Medical Association, through Dr. Billings, having been very cordially received. If so, our American confrères know well how to make it a success.

NEWSPAPER PARAGRAPHS.—Since our last issue we have received a number of newspaper paragraphs, containing reports of wonderful and rare "surgical operations" performed by medical men in different parts of the country. Some of these paragraphs are written in a style which makes only too apparent the source of their paternity. Others again are written in such a way that we may assume that they are the work of the "reporters." But it must be remembered that the code holds the medical men concerned responsible if their names constantly appear paraded in this way. In many of the towns and cities in this Province, and in other parts, medical men have been obliged to remonstrate against their names being used in connection with paragraphs such as above referred to.

Apropos of the above, the *Medical Times & Gazette* gives the following: — Members of the medical profession who have with reason made frequent complaints in our columns of the unprofessional advertisements appearing in the daily newspapers, will be glad to learn that, so far as the Royal College of Surgeons of England is concerned, an important step has just been taken calculated to check these practices by the removal, by resolution of the Council of that College, at a meeting on the 5th instant, of one of its Members, viz., Mr. George Washington Evans, who has, after careful enquiry and due deliberation, been judged by the Council to have been guilty of an offence against the by-laws of the College by the issue of advertisements and pamphlets declared to be "prejudicial to the interest," and "derogatory to the honour of the College," and "disgraceful to the profession of Surgery." The effect of this resolution will be that the name of George Washington Evans will also be erased from the Medical Register.

ONTARIO MEDICAL ASSOCIATION.—In accordance with a resolution passed at the last meeting the chairman of each temporary committee is expected to open a discussion next year on some subject to be named. The following are the subjects chosen:—*Surgery*—Chairman, Dr. Powell, Edgar— Subject: "Plaster Splints and Bandages." What fractures are best treated by them in private practice? What their advantages and what the dangers and limitations of their use? *Medicine*—Chairman, Dr. Tye, Chatham—Subject: "Diphtheria." *Ophthalmology*—Chairman, Dr. Ryerson,

Toronto—Subject: "On the use of Jequirity in affections of the eye." *Obstetrics*—Chairman, Dr. Temple, Toronto—Subject: "Intra-uterine medication."

CHILDREN'S TONIC.—The most pleasant and palatable disguise for quinine may be extemporized as follows:

℞—Quiniæ sulph.,	grs. xl.
Acid tannic,	grs. xx.
Tinct. opii camph.,	℥ ss.
Tinct. cinchona,	℥ ss.
Spts. lavender co.,	ʒ iij.
Syrup simp., ad.,	℥ iv.—M.

Shake well before using. The dose will be usually one teaspoonful three times a day, but the amount of quinia desired to be administered should govern the size of the dose. It will make a beautiful creamy mixture, if the quinia and tannin are rubbed together on a pill tile or a sheet of paper with a spatula until all lumps disappear, then put in a suitable bottle and first add the paregoric, shaking at once, then the cinchona and lavender, followed by the syrup.

DAVOS-PLATZ AS A HEALTH RESORT. — The merits of Davos-Platz, Switzerland, as a health resort are becoming more and more appreciated by the highest medical authorities of Great Britain. The place possesses the great advantage of salubrity at all seasons of the year, so that patients may be sent there the moment it is discovered that their health requires the aid of its pure, bracing, dry and rarified air, and can remain without interruption until their recovery is complete. Good accommodation, suited to the habits and wishes of English visitors, may be had at the Hotel Belvedere, under the management of Mr. Cœster, who will gladly furnish any information that may be desired.

BRITISH DIPLOMAS.—The following gentlemen have successfully passed the examination of the Royal College of Surgeons, England, and were admitted members—Drs. H. W. Aikins (Toronto); C. E. Gooding, G. B. Rowell, and J. B. Loring (McGill). The following have taken the L.R.C.P., London:—Drs. G. L. Airth, W. M. Brown, and E. H. Williams (Trinity); E. E. Bronstorph and A. Stewart (McGill); and J. F. Bell (Toronto). The following have received the double qualification of L.R.C.P. & S., Edin.:—Drs. S. A. McKeague, W. E. Sprague, J. Johnstoa, O. M. Belfry, R. Ovens, A. S. Thompson, and E. T. Eade (Trinity); J. Hutchison and W. Porteus (McGill).

ANOTHER CHOLERA COMMISSION.—We have had the French commission and the German commission, and now at the eleventh hour we are to have an English commission. Prof. Klein and Dr. Gibbes are to proceed to India and study the nature of cholera, and to act in conjunction with a native commission recently appointed. The gentlemen named are well qualified for this important work and their investigations will be of service to the world, but we fear that the earlier German commission has robbed them of whatever distinction they might have obtained in their investigations.

TREPHINING IN EPILEPSY.—Dr. Briggs, of Nashville, read a paper at the recent meeting of the Am. Surgical Association (*Am. Pract.*, July), in which he claims the most brilliant results from trephining in epilepsy arising from traumatic causes. In his record of 30 cases, he gives 25 cured, 3 relieved, 1 not benefited, and 1 died. No antiseptic precautions were used. Such results clearly indicate the propriety of resorting to the operation.

A GOOD DIURETIC.—The following combination recommended by Dr. Fothergill, will be found a useful diuretic:

℞	Pot citrat. ʒiiss.
	Spt. Juniper Co. ℥j.
	Tr. Digitalis ʒiiss.
	Inf. Buchu. ad. ℥viij.—M.

Sig. One to two tablespoonfuls three or four times a day.

MEDICAL LIFE PEERS. — An amendment has been proposed to the British Medical Act Amendment Bill, to the effect that two physicians of over twenty years' standing be made life peers, and act as lord justices of appeal in medico-legal trials. Some such measure has been frequently urged by members of the profession in England, and if carried out will considerably strengthen the hands of justice.

The passing of the British Medical Bill has been again postponed till a more convenient season.

HONORS TO CANADIANS.—Dr. Osler, of Montreal, is an applicant for the chair of clinical medicine in the University of Pennsylvania, made vacant by the transfer of Dr. Pepper to the chair of medicine. Should he be appointed the loss to McGill College will be seriously felt. He has also been invited to deliver the Gulstonian lectures before the Royal College of Physicians, London, next spring.

APPOINTMENTS.—Dr. J. M. Cochrane, of the assistant staff of the Toronto General Hospital, has been appointed medical superintendent of the Hamilton City Hospital. We congratulate our young friend and also the Hospital upon this excellent appointment

Dr. J. McDonald has been appointed to inspect all vessels arriving in the ports of the Miramichi District, N. B.

APPLICATION FOR DIPHTHERIA.—The following will be found a most useful formula :

℞—Liq. ferri subsulph.,	ʒ iv.
Acid carbol.,	ʒ j.
Sodæ sulphit.,	ʒ iij.
Glycerini,	ʒ ij.
Aquæ, ad.,	ʒ iv.—M.

Sig.—Apply by means of a brush or swab every two or three hours.

PRURITUS VULVÆ.—Dr. William Goodell, of Philadelphia, prescribes for this disease : carbolic acid, one drachm ; morphine sulphate, ten grains ; boracic acid, two drachms ; vaseline, two ounces. Also, pat the parts with a sponge soaked in boiling-hot water. This is also a most excellent application for that rawness so often found between the thighs of the newly born.

HYDROPHOBIA INOCULATION SUSTAINED.—The commission appointed to consider the question of the prevention of hydrophobia by inoculation as advanced by Pasteur, has reported in favor of the correctness of the distinguished scientist's theory.

THE death of Prof. Jäger, of Vienna, the distinguished ophthalmic surgeon, is announced ; also Sir Erasmus Wilson, of London, the well known dermatologist.

Books and Pamphlets.

THE AMERICAN SYSTEM OF PRACTICAL MEDICINE. Edited by William Pepper, M.D., LL.D., Philadelphia. In five volumes, with illustrations. Volume I., *now in press.* Philadelphia: H. C. Lea's Son & Co.

The publishers have just announced this magnificent work. For three years it has been in active preparation, and it is now in a sufficient state of forwardness to justify them in calling the attention of the profession to it as the work in which for the first time American medicine will be thoroughly represented by its worthiest teachers. A reference to the list of contributors will show the generous rivalry with which the most distinguished men from all the prominent centres of education, and from all the hospitals which afford special opportunities of study and practice—have united in bringing together this vast aggregate of specialized experience.

THE FIFTH ANNUAL REPORT OF THE ILLINOIS STATE BOARD OF HEALTH, for year ending 1883. Springfield, Ill. : H. W. Rokker.

The annual report of the Board contains besides the proceedings of the meetings, a mass of information on medical education and the regulation of the practice of medicine in the United States and Canada. It contains a digest of the medical laws and institutions in each of the several States of the Union, and also in Canada ; a list of Medical Colleges, Post-graduate Institutions, number of Physicians and Students, etc. It also contains articles on small-pox epidemics, vaccination, mortality statistics, and nomenclature of diseases, together with meteorological tables, all well indexed.

STUDENT'S MANUAL OF ELECTRO-THERAPEUTICS, by R. W. Amidon, A.M., M.D., Lecturer on Therapeutics at the Woman's Medical College, New York ; pp. 90. New York : G. P. Putnam's Sons.

This unpretentious little work aims at presenting, in the most concise language, that information necessary to the proper understanding of the construction and use of medical batteries. It also deals with the proper application of electricity in different pathological conditions, and the methods of electro-diagnosis.

*** *The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

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AN ADDRESS ON ABDOMINAL SURGERY.

BY LAWSON TAIT, F.R.C.S.E, BIRMINGHAM, ENG.*

Mr. President and Gentlemen,—Every gardener knows that a plant long grown on the same soil rises or sinks or somehow or other gets to a level from which it varies not so long as its conditions remain the same, and he knows as well that if he takes that plant to a new soil which suits it—if he grows it under new conditions—its growth, change, and development are practically endless. What we know of plants is, within limits, true of humanity; and if we require proof and illustration of this, where need we go but to this endless continent of yours.

I am not at present concerned with natural boundaries created by languages which come from Sweden and Poland, Denmark and Scotland, Russia and Ireland, which temporarily limit intercourse between different peoples who perhaps settled here. Still less do I trouble about a line on the map which marks a practical Republic on the south from a splendid Democracy on the north. I have only to do with the great fact of human history—I think the greatest fact—that from out of the troubles and distresses of our eastern countries, or out of countries oppressed by over-population, and still more by the effete policies of governments of past centuries dislocated into modern life, from these there has come a great country and a great people, whose growth, change, and development promise to be practically endless. Of my own country and my own people you will not expect me—you would not wish me—to say anything disparaging. We are an old and a respectable race, and, by virtue of your descent, you share that age, and you have brought over with you a full measure of the respectability. But in transit you have lost that questionable virtue of extreme conservatism which we retain in every conceivable phase of life. We used to have mail coaches protected against robbers by armed men, properly called guards, and we continue to call our railway servants guards without the slightest reason save that they seem to be in some fashion successors to the blunderbuss-bearers of the eighteenth century. On the other hand, you very properly call the same officials conductors. We still build our railway carriages in compartments fitted to hold six people, confined boxes that are stuffy, inconvenient, wasteful of room, and dangerous, and we do this only because one hundred years ago we built our stage coaches on the same pattern, and we thought, and we continue to think, that by sticking three of these old coaches end to end we must of necessity construct the very best kind of vehicle for railway travelling. Untrammelled by tradition, you have continued to build carriages far more convenient and suitable in every way. You have even sent them over to England for our use some ten years ago, but they had actually to be removed from our railways because the public would not use them. I might gather further illustrations of this intensely conservative spirit which governs everything English. I might wander into the regions of politics and religion and hundreds of other sources, but I prefer to take one of which I can speak at length and in detail—one upon which I believe, if I read aright the compliment you pay me by asking me to appear here before you, I can speak with some authority.

In my youth the medical education of a British student was not considered complete unless he had made a tour of the schools of France and Germany, and, like others, I felt of myself as was said of Proteus:

> "'Twould be a great impeachment to his age
> In having known no travel in his youth."

But I wish now that the time and money therein spent had been directed to the western instead of to the eastern continent. And I now predict that ere long it will be to the medical schools of America that our students will travel, as did the apprentices of old before they settled down to the serious exercise of their craft. For many years past I have been visited by numbers of my professional brethren from this side the Atlantic, many of whom

* Delivered before the Canada Medical Association, August 26th, 1884.

have settled down for days and weeks, and even months, to see my work. I have been overwhelmed by the kindliest invitations to visit this continent, but till now I have never ventured across. This delay is an instance of British conservatism, for it is very little the fashion amongst us to take long holidays. I have not had a holiday for seven years, and only the most eminent doctors in England take an annual outing; but on this side I find that none of you think much of a trip across the water, involving leaving your businesses for three or four months, and, from what I have heard, the struggle for existence is as keen as it is with us, perhaps keener. My American visitors have, one and all, impressed me with the feature of mind which I fear in England we do not possess—the power of judging any questian solely upon its merits, and entirely apart from any prejudice, tradition, or personal bias. No matter how we may struggle against it, tradition rules all we do; we cannot throw off its shackles, and I am bound to plead guilty to this weakness myself, perhaps as fully as any of my countrymen may be compelled to do. I may have broken free in some few places, but I know I am firmly bound in others; and my hope is, that my visit to a freer country and a better climate may extend my mental vision.

To come to my intended illustration, let me briefly remind you of the early history of abdominal surgery. The first operation for the removal of an ovarian tumor was performed unwittingly, in 1701, in a Scotch village; for Robert Houston began there a tapping, and finished by making a successful ovariotomy. It was not till 1809, eighty-six years after Houston's case was published, that his example was imitated, and even then it was not in Europe, but in the fresh soil of the backwoods of Kentucky that the young seedling obtained its first full growth, and from that time and from this country dates the history of abdominal surgery. But how slow the growth! In 1863 I heard my master, the Professor of Surgery in the Uhiversity of Edinburgh, settle all this vast field of human progress in these few words: "Abdominal surgery is abominable surgery." Syme, the greatest surgeon by far with whom I have ever come in contact, shared the views of his colleague in this matter, and I fear that in both the sentiments originated far less in the merits of the question than in their mutual dislike (almost the only sentiment they had in common) of John Lizars, who, having read Macdonald's manuscript when it was sent to John Bell, was immensely struck by the success of the heroic Kentuckian, and was desirous of following his brilliant example. Most unfortunately for humanity, the success of Lizars was of a very doubtful kind, and abdominal surgery had to wait for the advent of Dr. Charles Clay and Mr. Isaac Baker Brown. The story of the latter brilliant and unfortunate surgeon is now a twice-told tale, and I can only repeat what I have said at length elsewhere—that his disastrous downfall was a misfortune for humanity, delaying as it did the progress of abdominal surgery for fully a quarter of a century. The whole question of this progress lay in the peculiarly narrow issue as to whether the pedicles of ovarian tumours should be dealt with inside the peritoneum or outside it. Here, again, the new country was first in the race; for between 1820 and 1830 the decision in favour of the intra-peritoneal treatment was given in America in such a way that the question ought never to have been reopened. The arbitrament of abdominal surgery between 1866 and 1876 was left in the hands of a man still living, and he carried through his practice a mortality so heavy as to be absolutely prohibitive of fresh enterprise. Mr. Baker Brown left off practice in 1866 with a mortality of ten per cent. with the cautery, whilst, after operating on a thousand cases, Mr. Spencer Wells had a mortality of twelve per cent. in the last hundred with the ligature, and over the whole thousand the mortality was exactly twenty-five per cent. With such results as these, the marvel is not that the conservative surgeons cried out twenty years ago that the craft wa in danger, but that the removal of ovarian tumours ever became an accepted operation at all. As I have said over and over again, as I shall never tire of saying, to Keith is due the whole credit of the modern development of abdominal surgery, and it has ever seemed to me specially hard that while wealth and a title has been the lot of the man who had done nothing but obstruct progress, yet to the author of our present proud position, nothing has come save a good deal of misrepresentation and abuse. In 1878 the doctrines and practice of Lister, after twelve years of preaching on the part of Mr. Lister, had penetrated to London and were taken up by Mr. Wells and his assistants. I had practised all the details in

their ever-varying form, as recommended by Mr. Lister, from 1866 onwards, and gave them up one after another as I found they disappointed and hindered me. Finally I gave the spray and its adjuncts a long and complete trial—a trial far more careful in its details than anything I ever saw elsewhere, extending over three years. I have published in detail the disastrous results of this experiment, and at last gave up all these unnecessary dangers, and, since January 7th, 1881, my practice has been entirely free from all these details. Since then my example has been followed by Dr. Keith, Dr. Bantock, and by my colleague, Dr. Savage, and the only surgeon now who uses the Listerian details for abdominal surgery is Mr. Knowsley Thornton. He still claims for Listerism the most of our present progress, in spite of the fact that Keith, Bantock, Savage, and myself have all far better results without Listerism than Mr. Thornton has with it. Mr. Thornton went so far recently, as to say that his (Mr. Thornton's) bad results in hysterectomy were due to the fact that in this operation the Listerian details could not be effectually applied. But the facts of the practices of Mr. Thornton and Dr. Bantock, the two surgeons to the Samaritan Hospital, settle this question when they are contrasted. Mr. Thornton uses the Listerian details for hysterectomy as well as he can, and in twelve cases he has had five deaths, while Dr. Bantock does not use the Listerian details at all, and in twenty-two cases he has had only two deaths. The explanation of the difference will be evident to every one who has seen both of these gentlemen operate. To see Dr. Bantock do a hysterectomy is a lesson in surgery, and one from which I learnt a good deal.

To see my own work, I have been honoured with the visits of a large number of surgeons of this continent, some of whom I see here now. I believe they, one and all, came with a belief that they would find I had some secret antiseptic agent, the use of which was the explanation of my success. If I have such an agent, it must be of universal existence in nature, for I have made some of my visitors take the water from the tap and put it into the basins for the sponges, and over the instruments and into the abdomen. I have made them drink it, and have offered it to them for analysis, and, so far, I have not been detected in any magic exercise. My visitors always ask to what I attribute my success, and I answer that I cannot tell. They frequently suggest that it is climate. My answer is that our climate is the most variable and uncertain—the worst in the world. It is not fresh air, for the great majority of my operations, and always the worst, are done right in the middle of a large manufacturing town.

If I may formulate my own answers, they would be briefly to this effect: I have given up my life to this work, and I engage in no other kind of practice; therefore I have a constant weekly experience of five or six of these operations, sometimes as many as eight or ten. I pay the most minute attention to every detail, and maintain an absolute rule of iron over my nurses and my patients. I will not, if I can avoid it, operate in a private house, for there I have no control over either nurse or patient, still less over foolish friends. I can best illustrate the extent to which I carry discipline by telling an incident which occurred recently of a kind of which I have had a few, but not many, experiences. For my private hospital I have a rule that when a patient is admitted she must go to bed immediately. A lady with an ovarian tumour arrived, after a journey of some hundreds of miles, and was asked by the nurse told off for her, to go to bed. She said she would not do so until she had seen me. The nurse assured her that I would not come near her till she was in bed. The patient remained obstinate and I sent a message to her that she must either go to bed or go home again, and she elected to do the latter, with much satisfaction to myself. She doubtless thought and you may think, the rule in question is an absurd one, but the absurdity is only on the surface. It is a test of the patient's obedience and confidence in me, and I know very well that with a patient who begins by disputing my orders and doubting the wisdom of my directions, I never could get on, and therefore it is better for both that we should have an early parting. My nurses I always train myself—in fact, I will not have one who has had previous experience, for I know very well that such a woman will inevitably, to save herself trouble, do something in a way she has done elsewhere, and probably for some purpose altogether foreign to my intention, and will therefore become to me a source of danger and annoyance. Finally, I give great personal attention to

cleanliness in every detail of my work. I trust no nurses or servants without overlooking, and am constantly and at unexpected times turning up carpets, taking down shelves, and rooting out cupboards. In this way, and by a process of weeding, I have obtained a large staff of good servants, and have formed a large establishment in which every available precaution is secured. I can give no other reasons than these for my success, and probably they will commend themselves to you.

There are some causes intrinsic to the work itself from which the success has sprung to a large extent, and of which a few words may here be said with advantage. The first, of course, is the discontinuance of the clamp, of which I have said a great deal elsewhere. Whatever Sir Spencer Wells may say to the contrary, neither with nor without Listerism would anybody go back to the clamp. But the curious thing is that, from our recent experiences in hysterectomy, it would appear that it is not so much the clamp that has been to blame as Mr. Spencer Wells' method of using it. Hysterectomy must always be a more serious operation than an ovariotomy. But Dr. Bantock has now obtained better results in removing the uterus with the clamp than Mr. Spencer Wells ever got in removing simple ovarian tumours, and we must bear in mind that Mr Wells always insisted that he used the clamp for his simplest cases with long and easy pedicles. Puzzling over this mysterious and startling contrast, I went to see Dr. Bantock operate, and amongst other things I found he had given up using perchloride of iron for the purpose of tanning the stump. I asked him why he had done so, and he told me he was quite sure that the use of the perchloride of iron had added greatly to the mortality of the clamp, because with a thick pedicle secured by a clamp it is impossible to accurately close the abdominal wound and prevent draining into the cavity. I did not at once accept Dr. Bantock's explanation, but I determined to use the perchloride no more. Like everybody else, I was prejudiced in favour of the statement made by Mr. Spencer Wells, that a putrefying stump would poison the wound; and therefore I could not make up my mind to allow it to remain without some kind of interference. Years ago, in blaming the clamp for our high mortality, I had pointed out the likelihood of this incomplete closure as being one of the causes, if not the chief cause, of death; but I certainly did not suspect the perchloride of iron as being the fatal agent. A few days after my interview with Dr. Bantock I had to perform a hysterectomy, and I dressed the stump with crystals of thymol. The patient died of peritonitis on the fourth day, and that the thymol had trickled into her peritoneum we had proof enough. Since then I have done a hysterectomy without dressing the stump at all, and the patient has done perfectly well. It will be curious and no less instructive, if we find Dr. Bantock to be right, and that the use of perchloride of iron, the only contribution Sir Spencer Wells has ever made to abdominal surgery, should turn out to be the cause of his tremendous mortality. In any case, it is a remarkable example of how absurdly we are all governed by *a priori* statements absolutely void of any argument in support of them, and having been made by some one with an authoritative name and position, are accepted without doubt. If Dr. Bantock's brilliant results are obtained by others in the same way, then we have been going on destroying women with perchloride of iron merely because Mr. Spencer Wells said we should use it.

As the whole aspect of abdominal surgery is, at the present moment, controversial—as the progress and practice of this part of our art form the chief objects of my life, you need not be surprised if I have made this address somewhat of a polemic. The greatness of the opportunity—the fact that an address given to you will be read where mere utterances of mine would be passed by—obliged me to take advantage of the opportunity you have given me to carry on the discussion. The course of this particular line of work has, as you are all aware, taken a sudden bound of activity within the last few years, and the reason is a very simple one. The immense success of the removals of ovarian tumors such as threatened to destroy life with absolute certainty, which followed the efforts of Baker Brown and Keith, led some of us, myself especially, to venture into regions where life was not necessarily, or, at least, not apparently threatened, but where suffering was persistent and unendurable, and where the sufferers had been proved by protracted trial to be outside the powers of ordinary remedial measures. In a recent paper by Sir Spencer Wells, published in the *Med. Times and Gazette*, the argument is completely dislocat-

ed and put in an altogether *outré* fashion, and therefore I must here give a little attention to the views of that writer. He tells us that ovariotomy had, at one time, a mortality of 70 or 80 per cent., but I know not whence he gets his information. Doubtless it would be possible to find occasional examples of surgeons with a limited experience having such a heavy death-rate, but such isolated cases would not yield a fair statement of the facts. I read a few months ago in an American medical journal that in Italy there had been 100 cases operated upon with 53 deaths, and the newspaper recorded the fact that 34 surgeons were engaged in the sanguinary work. But when the work of men who can be called ovariotomists is examined, no such results are seen. Charles Clay was the first man who did ovariotomy in England, and his maximum of mortality in his first series of cases was 40 per cent., and it speedily fell to 25 per cent., and this is pretty much what has been recorded by Sir Spencer Wells of his own practice.

In the paper of which I am speaking, Sir Spencer goes on to say that "afterwards, when the strictest hygienic precautions were supplemented by antiseptics, and improvements in operative details were generally adopted, success became so great that ovariotomy not only took its stand as by far the most successful of any capital operation in surgery, but the risk attending it in a favorable case could truly be calculated as little, if at all greater, than that attending any case of natural child-birth, and, as a necessary consequence, early operations can be advised with less hesitation." The statements in this quotation are wrong from beginning to end. In the first place, the mortality of ovariotomy in the hands of Keith and myself still remains at or about three per cent., and we have shown the least mortality yet available. The mortality of natural labor, on the other hand, is certainly not .25 per cent. The statement that a diminished mortality has led to early operations ought to be exactly reversed, for it is the early removal of tumors and the discontinuance of tapping which have largely contributed to our present splendid results. Sir Spencer Wells' teaching inculcated the practice of tapping and its repetition until the patient was within measurable distance of the grave, but his successors have reversed all this with infinite advantage to their patients, and we now look upon tapping as a sort of surgical crime. This material alteration in practice led us, step by step, in the direction I have indicated, and we began to discuss the greater advantage to which I have just alluded. Every specialist is familiar with the large class of miserable women who wander about from hospital to hospital, or from consulting-room to consulting-room, seeking relief from their ailments unavailingly.

Let me take the first class to which Sir Spencer Wells alludes in his recent paper on cases of uterine tumor. There can be no doubt but that there are hundreds of uterine tumors that give no trouble at all, but these are not the cases that come to us. If a woman has no pelvic trouble, she does not present herself to the gynæcologist, and if she has a uterine tumor which gives rise to no symptoms, that tumor, of course, remains undiscovered. But when she suffers from distress occasioned by pressure on the viscera, from severe hæmorrhage, or increasing size, she comes to us and asks for advice. Suppose we find her suffering from a uterine myoma, what are we to do? The answer to this question is like the answer to every other of a similar kind. If the tumor is small, the woman comparatively near her climacteric, and the hæmorrhage such as can be moderated by rest in bed and the use of ergot, then she can be advised to let the tumor alone; but if the woman be not near her climacteric, and the hæmorrhage does not yield to treatment, especially after a fair trial of treatment, the tumor is found to be actually going on, then surgical treatment is demanded. Of course, each practitioner of medicine does, and always must, carry on his work in his own way, and there can be no doubt that within certain limits the measure of his success stamps the rightness or the wrongness of his methods. James Syme used to teach us that there were three methods of conducting our professional business, but that there was only one way to real success. He said there were three interests involved. The first in order is that of the patient; second, that of the professional colleague; and third, that of the practitioner himself. Syme insisted that the several interests should be rigidly kept in the order in which he placed them, or things would be sure to go wrong. I have never heard sounder advice. I have never lost sight of it, and so far as within me lay I have striven to follow it. In the proposal of a new proceeding two dangers clearly occur. The first is that of the

enthusiastic upholder of the novelty; he may be disposed to run too fast on the new line. The second is that of the obstructive who, merely a believer in the times that are past, can see no possibility of their improvement. For the first danger the remedy is a wholesome scepticism, leading into just and careful criticism; the remedy for the second is more difficult, for it involves the patient endurance of much misrepresentation, and a protracted combat upon the points of criticism which have no weight in themselves, and have an importance gained only by persistent reiteration. In the line of practice of which I am about to speak, the point most persistently urged against our new line of practice is that unnecessary operations are performed. Now, this is an argument which it is extremely difficult to argue upon, because those who speak on the two sides of the question start from altogether different standpoints. Those of a past generation, like Sir Spencer Wells, apparently regard it as justifiable to perform operations in this department of surgery only when life is pronouncedly in danger; we, on the contrary, of the younger school, believe we are justified in extending our practice for the relief of suffering, and we regard this as a higher function than that of the mere saving of life. To end the discussion on this point, I would point out that our critics endeavor to apply an arbitrary rule for the repression of abdominal surgery which has never yet been applied in any department of the art. Let me ask, if we find a man suffering slightly with the early symptoms of a small calculus, do we not at once proceed to relieve him by removing it from his bladder? In fact, in the domain of what is called general surgery, has it not become the established practice to perform operations which are accompanied by very considerable risk of life merely for the rectification of deformities, such as bowed-legs and knock-knees, which have not the remotest risk of life attached to them and which involve no kind of suffering. The ultimate court of appeal comes then to be the patient's own decision, and I do not find that persons prefer to go on suffering pain and the disabling effects of profuse loss of blood rather than submit to a surgical operation, the details and effects and ascertained risks of which are completely and candidly placed before them.

In the treatment of uterine myoma two alternatives occur, and these are both the subject of very hot discussion on my own side of the Atlantic; they are the removal of the uterine appendages, and the removal of the uterine tumor itself by the so-called supra-vaginal hysterectomy. No one in Europe, at least only one so far as I know of any importance, doubts that removal of the uterine appendages arrests menstruation completely in the great majority of cases, arrests the growth of uterine myoma generally, and in many instances causes it to entirely disappear. Mr. Knowsley Thornton, Dr. Savage, Professor Hegar, myself ond others, have reported numerous cases in detail. I have published a long series in the *Am. Jour. of Med. Science*, but Sir Spencer Wells dismisses us all in the brief sentence: "Vague, unsupported assertions have little influence upon the opinion of a thoughtful or a sceptical profession." Sir Spencer Wells must pass his retirement in some other occupation than in perusing the modern literature of his specialty, and therefore his criticism need hardly engage our attention.

The great majority of cases of uterine myoma, which come to us for surgical treatment, can be quite satisfactorily dealt with, and it is an operation having a small and steadily diminishing mortality. Since 1878 I have performed it many times with few deaths, but am unable to give the exact figures just now. The arguments used against it are, first, that of its mortality, but this mortality is the inevitable result of early work, and is therefore not a permanent objection. It was an objection urged twenty-five years ago against ovariotomy, but it no longer holds good against that operation. The second objection is that myoma itself is not a fatal disease, but this argument is not in harmony with my own experience. Even if it were a just one, however, it is admirably met by the plea entered at Ryde by Dr. ——, of ——, in the discussion of my paper on the subject, to the effect that it is to the rights and relief of the majority that we must have regard, and that the function of our profession does not end with the saving of life, but is chiefly that of relieving suffering.

Two other objections have been urged generally against the removal of the uterine appendages—that it sterilizes and destroys the patient's sexual appetite. Of course, a woman is completely sterilized by a uterine myoma ninety-nine times out of a hundred, so that the process of complete destruction of fertility is a matter of little moment. The other ob-

jection has been shown to be perfectly groundless, but even if it were not so, it could hardly be urged on the ground of morality that a woman should go on suffering because she ought not to suffer any diminution of that animal propensity which it is the chief object of the higher life of all religious culture to subject, and the subjection of which forms for all creatures the greatest difficulty in existence.

There are cases of myoma demanding surgical treatment upon which removal of the uterine appendages seems to exercise no satisfactory influence. Mr. Knowsley Thornton has made a very valuable suggestion—one which certainly deserves very careful consideration—that all cases of myoma requiring interference are first to be subjected to the removal of the uterine appendages, and then to subsequent operation if it should be necessary. The only objection to this I can offer at present is an incomplete one. I have pretty well satisfied myself that there is one form of myoma on which removal of the appendages exercises no control. The variety I have named the soft œdematous myoma. But it is not easy to recognize this form of tumor until after it has been removed. Again, there are a few cases, very few I have found them to be, in which the appendages cannot be removed, and we must proceed to hysterectomy. Finally, the removal of uterine tumors has had such brilliant results in Bantock's hands that I am in hopes that a new era for hysterectomy is being opened out.

Another class of cases wandering about after relief are those upon whom I have operated in large numbers, and have found chronic and incurable disease of the appendages in the form of chronic inflammation of the ovary, chronic inflammation and occlusion of the tubes, these latter being occluded and distended by serum, pus, or blood. When I first published my work on this subject there was, of course, a large amount of incredulity expressed about it, and this incredulity was not much lessened by the exhibition of a large number of specimens at various societies, and their permanent exhibition in the museums of the colleges of surgeons. Many, particularly amongst my metropolitan brethren, loudly asserted that there were no such diseases, and Mr. Spencer Wells stated at the International Medical Congress in London that if such cases did occur they must all go to Birmingham. But Dr. Kingston Fowler has shown not only that they exist in London, but that they are far more fatal than I had any idea of, and that they have been and are overlooked and misunderstood in the metropolis just as they were overlooked and misunderstood in my own practice previous to 1878. Concerning this incredulity, please distinctly understand that I don't blame anyone for it. It is a necessary part of all human progress. I do not even blame my metropolitan brethren, as they seem to think I do, for not discovering these cases and properly treating them. That is the fault of the mechanical school of gynæcology established by Simpson, and which still exercises a far too great influence over this department of our art. During the last twenty years displacements have had a great run, just as before that time everything was put down to ulceration, and no man considered himself properly armed for the treatment of disease unless he carried a speculum and a caustic stick about with him in his gig. The mechanical school revels in the sound and pessary, both useful enough instruments in their proper places, but, when misused, capable of endless mischief, for many of the so-called displacements are now known to be constituted by chronically inflamed and adherent tubes and ovaries which can be relieved by removal only.

You will ask me, at starting, to tell you how this disease may be recognized, and I have to answer that their diagnosis cannot now, and probably never will, be a matter of certainty. They begin generally in some acute attack of pelvic inflammation, from which the patient dates all her troubles; and when you get such a distinct history you ought at once to be on your guard. This illness may have arisen, for instance, in a closely-confined and confessed attack of gonorrhœa; or it may be an attack of pelvic perimetritis, occurring after a miscarriage or a labor; or it may have arisen in one of the exanthematic fevers or a simple cold. In some of the cases, however, you get no clear starting-point in the history, and then the diagnosis is generally more difficult. The symptoms are usually precise enough, yet unfortunately none of them are peculiar to the condition of which we are speaking. Pain is, of course, a leading feature; indeed, it is rarely without pain as a chief incentive that patients consult us at all. This pain is complained of as being constantly present, greatly aggravated by

walking, and becoming intense for some hours or days before the period, and lasting throughout its continuance. Menstruation is usually too frequent and too profuse. In the great majority of the cases the uterus is somewhat fixed, and a tender mass can be felt on one or other side of it, perhaps on both sides and behind it. When the tubes and ovaries are down behind the uterus and adherent there—and this is by far the most common condition—the diagnosis to a beginner is very difficult. Nothing looks more certain and easy than the diagnosis of subinvolution and retroflexion, and without further considertaion a pessary is introduced, with no other result than that of aggravating the patient's sufferings; in fact, I may say that at this point her troubles will begin to be serious, and she will wander about to collect various kinds of instruments from various practitioners, until she ends either a helpless and hopeless invalid or dies from an attack of acute peritonitis. In some of my most marked and most successful cases there have been no physical signs whatever, and I have felt myself reluctantly justified in interfering only by manifest reality of the patient's sufferings.

Here let me just say a word about the much discussed question of subjective symptoms. Everybody has heard the celebrated story told of Liston —that a hysterical girl persuaded him to remove a healthy limb for supposed disease of the knee-joint. But is there any other story of the kind known? If there is, I have not come across it. We certainly do meet with women who will tell the most extraordinary and incredible stories about their sufferings; but the stories are so inconsequent and contradictory that there is no difficulty in discounting them. Besides, they have no support from the presence of corresponding physical signs. A woman whose story is real has a sequent narrative, and she will submit to treatment; while the woman who is a humbug flies off in a temper the moment the suggestion is made that she should submit to an operation in which she risks her life. I have never yet known a woman submit to an abdominal section in whom I did not find abundant justification for its performance, even in cases where I had been extremely doubtful about its real necessity before I undertook it. I have known many patients to whom I have made the proposal as a test of their reality, and who have, much to my satisfaction, speedily taken themselves off to some other practitioner.

Of the details in these operations in these cases I have no time to speak. Indeed, I could deal with them satisfactorily only in a series of lectures. Suffice it to say that the operations are extremely difficult, for the structures are always very adherent, and the operator has nothing to guide him save the erudition of his touch. Concerning the cases of occluded and distended tubes, some of my critics have suggested, without any experience, that something short of abdominal section might suffice for their successful treatment, such as tapping the tubes from the vagina. But a trial of this proceeding long ago satisfied me of its impracticability and its uselessness, and my growing experience confirms me in the conclusion that we have no alternative. I am often asked concerning the subsequent history of these cases, and I am able to say I have published the details that the great majority of them are relieved at once and completely by the operation. There remains a tenderness of the stump in some of them for some months. In four very bad cases fæcal fistulæ formed, but in two the sinuses have healed and the patients are perfectly well. In the third case the fistula opens still at occasional intervals; and in the fourth case, by far the worst I have ever had, the patient being literally at death's door when the operation was performed, the fistula still remains, some twelve months after the operation, but even here her health has so greatly improved that I am hopeful of its permanent closure in time.

I have occupied your time already at too great length, and yet have left myself no time whatever to speak of a great variety of topics within the limits of the subject of my address of which I fain would have spoken—subjects entirely novel, and full of the deepest interest alike to the practical surgeon and to him who takes but an interest of a literary kind in the progress of our art. In fact, it is a matter of regret to me that I cannot address such an audience as this in a series of lectures rather than in an address which must necessarily be brief. It is one of the great defects of a position such as I hold—a defect inherent to a special line of practice—that it practically shuts out its follower from any chance of being a teacher. Besides this, I feel strongly as acting to my own

prejudice, and I am certain it is a misfortune that those who, like myself, are very largely engaged in work strictly limited to a department, can never communicate as successfully the results of their experience as can those who are engaged in teaching. I regret, therefore, that I must pass over without mention the important field of new work which has been opened up within the last few years in the surgical treatment of the liver, spleen, kidney, and intestines. I cannot even stop to speak of many other less striking, but no less important subjects, such as the treatment of pelvic abscesses by abdominal section and drainage, though all these are of less importance, in so far that they excite but little hostility; and what I have to say further to you I propose to limit to a brief discussion of a proposal made by Dr. Battey for the production, artificially, of the menopause for the purpose of indirectly benefiting patients from conditions more or less neurotic, the symptoms of which are apparently influenced by the recurrence of menstruation. It must be perfectly clear to the most casual observer that this is a field of an extremely ill-defined character—one which, at first sight, offers very intangible prospects of success, and in which the indications even of success must be very vague and indefinite. There can be no doubt that a large number of women suffer in such a way as to make it perfectly clear that if they were relieved from recurrent menstruation they would be improved materially, but there can be as little doubt that the application of this idea—in itself a brilliant one—requires the utmost care. I have no sympathy with stupid obstructionists who, because they scent danger in the air, would absolutely prohibit its application; but I have sufficient regard for the expression of every kind of professional opinion to recognize the necessity for the full exercise of caution. When the proposal was first made, I recognized this so fully that I selected for whatever experiments I should make in this direction a disease concerning the reality of which there could be no doubt whatever: I mean epilepsy. It is a perfectly easy thing to recognize by two facts alone any case of genuine epilepsy from mere hysterical imitation. It was, I think, Dr. John Hughes Bennett who clearly established the facts that none but the true epileptics ever seriously hurt themselves during the attacks, and that after the fits are over the epileptic is always somnolent. It is certainly the case that in a large number of cases of epilepsy in women the incidence of the disease is concurrent with menstruation. It is also true that every epileptic woman, certainly whose case I have investigated, is worse during the menstrual week than at any other time. In some cases the epilepsy is absolutely limited to those days of the month during which the menstrual flow is in existence. It was, therefore, a perfectly easy thing to select a number of cases in which the experiment of Battey's operation seemed capable of justification. For the purpose of trying the experiment I selected six cases, and to these I have absolutely limited its application, though from the number of cases who have been sent to me for the specific purpose of having the operation performed, I suppose I might have been able by this time to have placed several series of attempts on record. The reason of my careful restriction has been that I did not care to prejudice the results of my other work by complicating it with what seemed to me a doubtful kind of proceeding, but all my care has been to some extent fruitless, for I have been persistently charged by a certain class of writers with having performed a large number of useless and unnecessary operations in removing normal ovaries from women suffering from nervous disorders. Indeed, so late as July 5th last, Sir Spencer Wells wrote the following sentences which, though they may have been intended for some one else, I cannot but suspect were levelled at me. They are as follows: "Just now something more than a word of caution against rash, dangerous and unnecessary operations is called for. We are startled by the reports of the removal of normal ovaries of young women suffering from nervous disorders, which may be exaggerated or imaginary; and it is to be feared that our professional honour is at stake, and that abdominal surgery in its latest developments is open to the denunciation hurled against the earlier ovariotomists, and that with more reason than in 1850. Lawrence's question must be repeated, whether such operations can be encouraged and continued without danger to the character of the profession, and West's assertion that the fundamental principle of medical morality is outraged, cannot now be satisfactorily refuted."

Though I am fairly familiar with the literature of abdominal surgery during the last ten

years, I am absolutely ignorant of anything which can possibly justify such ridiculous exaggeration. I have publicly challenged Sir Spencer Wells to indicate the proceedings to which he alludes, and to produce the evidence upon which he bases his charges; but up to the moment of my leaving England he had not taken up the gauntlet. It is a somewhat remarkable fact that, in another journal of the same month, the same writer actually pleaded in favor of the removal of tubercular lungs, that such an operation would be justifiable if it saved one patient in twenty of those operated on, and it seems to me absolutely impossible to reconcile such a recommendation with the denunciation I have just read. So far as my own work in Battey's operation is concerned, in not a single one of the six patients operated upon were the uterine appendages normal. Two of them were carefully investigated by independent observers, one of whom was the well-known and accomplished pathologist, Mr. A. Doran, by whom the specimens were fully described and figured, in the *Brit. Med. Journal.*

The results of these operations were, in the first place, that all the patients made easy and uninterrupted recoveries; the operations were performed after the most careful consultation, and with the full cognizance on the part of the patients and their friends of the results which were certain, and the entire speculative nature of those it was hoped would be obtained. As I have already published the cases in detail, with the exception of the last, which was only performed a few weeks ago, I need not here repeat them, save in general terms, and that is to the effect that in two cases the results are such as to completely justify the proceeding. In both of these the disease before the operation was so intense that it was threatening life, but now it is almost entirely subdued, and the health of the patients has been enormously improved. In one case, the disease was arrested for a year and a half, and though it is now returning the patient has been transformed from a wretchedly feeble and broken-down girl into a healthy and robust woman, although affected by epilepsy almost as badly as before. In two others, the disease has been greatly modified, and the health of the patients has been immensely benefited. From this brief record it is quite a matter open for discussion as to whether the continuance of the proceeding can be recommended, and I am bound to say that I have not myself a very strong opinion in the affirmative; but I think, if I had a daughter with feeble health, the result of pronounced menstrual epilepsy, I would advise her to have the operation performed. From what I have seen of it myself, I think there can hardly be any risk about it, and if performed with the precautions indicated, I do not think it can be brought under the sweeping category of Sir Spencer Wells as being either rash, dangerous or unnecessary. There is another argument, and I think one that may be said to have some moral force, in that it will assist in the prevention of the distinctly pronounced hereditary tendency of the disease, and we should at least hesitate before we entirely condemn it. Certainly a great deal more can be said for it than for the proposal of pneumonotomy for phthisis, on the assumption that the removal of a lung would only save one patient out of twenty. Removal of the uterine appendages for epilepsy would probably not kill more than one per cent., and I am certain it would materially relieve fifty per cent.; it would improve the health of the great majority of patients, and I don't think it would make any of them worse than they were before the operation. I am hopeful, therefore, that the verdict of professional opinion will not be adverse to a fair and reasonable trial of Dr. Battey's proposal, and I trust that the freedom from the prejudice and the shackles of tradition which we find on this side of the Atlantic will secure for it a fair field.

And now, in conclusion, let me thank you most sincerely, and not only you, but many other professional bodies and large numbers of professional friends, for the kindly, I may say overwhelming, reception I have met with at your hands. For many months before I left home, there arrived hardly a mail which did not bring me invitations to partake of public or private hospitality, and these kind expressions of regard brought forth feelings of deep regret that my stay here could not be prolonged for as many months as it is limited in days. There is one thing in this reception I recognize above all others, and it is, that you are treating me not on account of any merits of my own, but as the representative of a large body of men in my own land to whom you have owed much in the past, and with whom you are in the present united in a common bond of brotherhood and community of sacred purpose. I predict that in the future this union and unity will be more and

more complete. That it ever should be endangered would be a diaster for humanity. As the blunder of a century ago, which severed from the old country her most prosperous children, kept the whole progress of the world in abeyance for nearly two generations, so any future instance would be more diastrous still· God grant that we may never see it !

Dr. Grant, of Ottawa, in a few appropriate remarks moved a vote of thanks to Mr. Lawson Tait for his admirable address, which was seconded by Dr. Brodie, of Detroit.

Dr. McMillan, of Hull, Eng., doubted the advisability of removing the ovaries when no objective signs were present. He thought that Sir Spencer Wells' remarks on this subject were addressed more especially to young men, whose experience might be less than their enthusiasm, and not to men of large experience.

Dr. Trenholme, of Montreal, said he had performed the operation of removal of the ovaries twelve years ago, in a case where there was severe menorrhagia and metrorrhagia, with marked benefit to the patient. In recent years he had performed the operation frequently, and the results were, as a rule, satisfactory.

Dr. Hingston, of Montreal, congratulated Mr. Tait on his and Dr. Keith's disuse of Listerism in abdominal surgery, and thought the splendid results they had obtained were largely due to it. He thought with the speaker that the use of the perchloride of iron was a mistake. He took exceptto the criticism on Sir Spencer Wells, and thought that public opinion, which had pronounced unmistakably in Wells' favour, was not a bad criterion. He disapproved of Mr. Tait's rule as a guide to the necessity of an operation, namely, that serious cases submit to operations and the hysterical do not. His own experience was that the hysterical carried out their acting to the end, at least in America, and gave an instance in illustration, where he had been implored to remove the appendages in a young person ; he declined ; the patient afterwards married, and all the symptoms had disappeared. He thought that when the objective signs were clear, no hesitation should be experienced in operating ; but when the signs were altogether subjective, operations would be performed that were unwar rantable. An unnecessary operation of this nature was a crime against society, and it interfered with the interests of the state. He did not agree with Mr. Tait that the operating surgeon could place the responsibility on the shoulders of the general practitioner who had advised the operation in the first instance. He gathered from the fact that only a few (6) out of a large number of cases of epilepsy had been selected for Battey's operation, that Mr. Tait did not favor it.

Dr. Brush, of Utica, N.Y., referred to Dr. Miner's operation of ovariotomy by enucleation, and said it had been his pleasure to watch the impetus which that valuable and unique suggestion gave to abdominal surgery.

He regretted that Mr. Tait did not refer to the removal of the uterine appendages in certain cases of insanity, to hasten the menopause. Prof. Wm. Goodell, of Philadelphia, has reported a few cases in the *Am. Jour. of Insanity*, in which he had successfully performed Battey's operation for the relief of insanity in patients in whom there was marked increased mental disturbance associated with the menstrual flow. With these cases in view, and bearing in mind Mr. Tait's statement that a mortality of not more than one per cent. need be feared, he would go home with increased faith in the propriety—nay, even the necessity—of the operation, in certain cases.

Dr. Heywood Smith, of London, said he agreed with Mr. Tait as to the greater difficulty in the operation for removal of the uterine appendages as compared with ovariotomy. As to the effect of the operation on fibroid tumours, his opinion was that it was of more use in cases of soft tumours than in those of a more dense structure. He had seen cases where, after the removal of both ovaries, profuse hæmorrhage continued so as to endanger the patient's life. But in cases of severe dysmenorrhœa, the result of chronic ovaritis and subsequent morbid changes in the ovary, he was convinced that the removal of the ovaries held out the best prospect of cure. He approved of Listerism, but occasionally used eucalyptus, which had this advantage over the carbolic spray, that there was no noise nor wet fog. In reckoning the advantages of the spray or the reverse, we must be careful to estimate the growing experience of each operator, and not hastily set aside Listerism under the idea that it is useless or worse, when increased success may most probably be due to the increased experience in operating. Under the use of anti-

septic measures at the (N. British) Lying-in-Hospital in London, the mortality during the past three years had been reduced to .062 per cent. He also said that the removal of the ovaries did not interfere with the sexual appetite, nor did it make women scraggy; on the contrary, many became plump after the operation.

Dr. Farmer, of Montreal, said he had been in the habit of removing submucous myomata which caused dysmenorrhœa, menorrhagia and metrorrhagia with Thomas' serrated spoon, and would like to ask Mr. Tait if he considered the removal of the appendages safer or more effectual in such cases.

Dr. Protheroe Smith, of London said he thought that the discontinuance of bleeding, by favoring congestion of the internal organs, had made ovarian disease much more common in recent years.

Dr. Fulton, of Toronto, asked Mr. Tait if there were not cases in which tapping as an aid in diagnosis was admissible? And if in some cases where there was extreme distension of the abdominal walls, it was not safer to withdraw a portion of the fluid to reduce the distressing symptoms?

Mr. Lawson Tait, in reply, said that as Sir Spencer Wells had never hesitated about knocking other people over the knuckles, he must not expect to escape similar treatment. Mr. Tait had only to say that any criticism he had ever made of Sir Spencer Wells was with most friendly intentions, dictated by an intimate acquaintance extending over many years.

Dr. McMillan and Dr. Hingston had both somewhat misunderstood what he had said about operations performed in the absence of physical signs. Those cases were absolutely limited to three cases of epilepsy and about three others in which the operation was urged, and the whole responsibility of its performance was accepted by the medical attendant in charge of the case. Such an instance was published by Dr. Ertuby in the *Lancet* about three years ago. Dr. Ertuby pressed me to perform the operation, and undertook its whole responsibility. As we found pyo-salpynx, the operation was entirely justified. The real protection alike of patient and surgeon is the introduction of the family physician, by whose concurrence the possibility of the performance of an unnecssary operation would be reduced to a minimum. It must, however, be remembered that surgeons who practise this department of the profession are as fallible as other human beings, and that with them mistakes must as surely occur. They are to be judged, and their works also, by the same standards applied elsewhere, and not by others of an unjust and more exacting character.

In answer to Dr. Gardner, he would say that his own experience was wholly in favor of removal of the uterine appendages as a far safer operation than enucleation. Not only so, but as fresh tumors had grown after enucleation and removal of the appendages was ultimately required, he thought that the latter operation was in every way preferable.

He did not agree with Dr. Protheroe Smith regarding the lancet. There could be no doubt that ovarian disease was on the increase, but he could offer no explanation of the cause thereof. It certainly did not lie in the discontinuance of the practice of bleeding.

In reply to Dr. Fulton, Mr. Tait had to say that tapping never could help in a diagnosis as an exploratory incision could, and it was quite as risky. A small two-inch incision revealed in most cases the precise nature of the tumour, and allowed all fluid to be completely evacuated, if nothing more could be done. In some cases of great distension the removal of fluid before operating was advisable.

CASE OF ANDROGYNÆ.

BY J. ALGERNON TEMPLE, M.D., M.R.C.S.

Prof. of Obstetrics and Diseases of Women and Children in Trinity Medical College, Toronto, etc.

A few days ago a peculiar case of malformation of the genitals in a female, came under my notice.

Mrs. D., aged 23, married 5 months, consulted me for amenorrhœa. The build of the patient was decidedly masculine, her voice deep, and a considerable quantity of soft dark hair on her upper lip and side of her face. She told me she had never menstruated, and that she experienced a considerable amount of sexual excitement during coitus. On making a vaginal examination, I found the canal not more than 1½ inches in depth, mons veneris covered with hair. The clitoris was about one inch long, with a complete prepuce, and the meatus urinarius opened about ¼ inch below it. The mucous membrane lining the vaginal orifice was of a peculiar dark red, with com-

plete absence of the labia minora. On either side of the mons, two almond shaped bodies were to be felt, tender to the touch, easily moved about towards the external abdominal ring, with a round cord attached to their upper ends. These bodies, from their size and shape, resembled more the testicle than ovaries. Through this short vaginal canal I could not detect any uterine body, and on a careful examination per rectum, I satisfied myself that this body was absent. By bimanual examination I could meet my two hands. Firm pressure above the pubis, and the finger in the rectum proved to me that no uterus existed, and retaining one finger in the rectum, and a sound in the bladder, I could bring them together easily, proving the non-existence of the uterus. This patient has been for some five or six years taking medicines for the purpose of bringing on menstruation, without having undergone any examination to determine the cause of the absence of this function. Complete absence of the uterus is not a common malformation.

THE EXCLUSION OF STRYCHNIA AND ARSENIC FROM ALL PREPARATIONS NOW IN COMMON USE.

BY GEO. PRINGLE, M.D., C.M., CORNWALL, ONT.

That strychnia is an invaluable remedy is unquestionable; that it is the cause of serious mischief in some cases, even where every precaution has been taken and every fact that could decide for or against its use been most carefully gleaned, is equally unquestionable. Having prescribed it during many years under most guarded rules for female patients, both married and unmarried, with good results, I have lately met with three or four cases the peculiarities of which I think well to bring before the profession, not so much for any practical lesson they teach as the moral they especially point, convinced that our failures, as we must have them, if properly noted, teach us more valuable lessons than our successes.

As the symptoms which indicated the employment of chalybeates with strychnia were much the same in all, I will not take up your space by describing more than one, but will give the result of the treatment in each.

CASE I. Mrs. J. K., æt. 30, mother of three children, consulted me in Jan. 25, 1883. She was of slight figure, complained of headache, vertigo, failure of sight, ringing noise in the ears, unpleasant taste in mouth and throat (especially in the morning), palpitation on the slightest exertion, poor appetite, bowels constipated, in short, functional derangement of every organ, but no disease, merely prostration. She was still nursing her fourth child, then fourteen months old; was perfectly sure she was not again pregnant; never had a return of menses since the conception of her first child, and never felt any of the unpleasant symptoms of pregnancy, but knew when she was so, as her children began to fail. The difference in the ages of the children ranged from twenty-two months to two years. Finding nothing pointing to pregnancy, I at once put her upon the following mixture :—

℞—Tr. calomb.,
Tr. rhei co., *aa* ʒj.
Acid nit.-mur. dil., ʒiv.
Liq. strych., B.P., ʒj.
Elix. iron et gent., ʒj.
Aqua ad., ʒiv.—M.
SIG.—One teaspoonful in water after each meal.

Ordered a podophyllin pill twice a week at bed time; also the immediate weaning of child, and to report the result of treatment in about two weeks.

CASE II. Was nursing her first child, then four months old, child large for its age; had no return of menses. I prescribed the following :—

℞—Elix. iron, calisaya et strych., ʒiv.—M.
SIG.—One teaspoonful after each meal.

Advised weaning the child, and rest as adjuvants; cautioned her as to the mixture and asked to know the result in about two weeks.

CASE III. Was the mother of three children; was nursing the third then four months old; her menses had not returned and did not usually do so until her children were ten months or a year old. There were no signs of pregnancy. I prescribed the same as for Case 2 and asked to hear result.

CASE IV. Was similar to Case 1, only I was more particular in my questioning if possible. The principle of treatment was the same as before, with a request to hear the result.

Now as to the result. In three cases out of the four the result was an abortion. Case 2 complained of most severe bearing-down pains, as in labor, and

painful micturition. Of her own motion she stopped the mixture for a time, the painful symptoms at once ceased, but upon again renewing her treatment they began to return, when she stopped it entirely. I then gave her a tonic, without strychnia, which benefited her at once. Case 1 had an abortion, but not for some time (about two weeks) after finishing her mixtnre. Case 3, whose infant was only four months old, had an abortion very soon after commencing her tonic. She stopped it while ill, began it after recovery, with no other ill results. Case 4, to her astonishment, also suffered an abortion, the first one in her life.

REMARKS.—Now admitting, for the sake of argument, that there are many causes, over which patients have no control, quite sufficient to produce abortion; admitting also that these three cases may have been merely accidental, they are very unpleasant, not to say dangerous, and as I do not care to run any more risk of such occurrences, I have therefore ceased prescribing strychnia for any patient where conception has taken place.

The moral pointed is this: In nearly every tonic elixir, strychnia forms an ingredient, and amongst the laity many do their own prescribing where a tonic only is needed, although the principle is a bad one. When one reflects, therefore, that these elixirs are often prescribed in this way, many of them containing not only strychnia but arsenic, he cannot but ask himself the question, if so much mischief may be done quite unintentionally in such cases as mentioned, how much more may be done designedly?

I would suggest that, if it be possible, the profession should unite in urging upon manufacturers the propriety of excluding both strychnia and arsenic from all elixirs and leaving these two dangerous remedies solely in the hands of physicians.

Reports of Societies.

CANADA MEDICAL ASSOCIATION.

The seventeenth annual meeting of the Canada Medical Association was held in Montreal on the 25th, 26th and 27th August. There was a large attendance of members from all parts of the Dominion.

The President, Dr. Sullivan of Kingston, took the chair at 10.30 a.m., and Dr. Hingston, chairman of the Local Committee of Arrangements, welcomed the members on behalf of the profession of the city of Montreal. Mr. Lawson Tait of Birmingham, Drs. McGraw and Brodie of Detroit, Dr. Murphy of Kansas, and Dr. McMillan of Hull, Eng., together with the past Presidents, were invited on the platform.

The minutes of the last meeting were read and approved. A large number of new members were proposed and elected.

Dr. Fulton read the report on Necrology, giving the names of members who had died during the year.

The Secretary read the report on public health by Dr. Canniff, and it was referred to the proper Committee.

The following officers of sections were nominated by the President, viz: *Medical Section*—Chairman, Dr. Thorburn, Toronto; Secretary, Dr. Burt, Paris. *Surgical Section*—Chairman, Dr. Roddick, Montreal; Secretary, Dr. Tye, Chatham. The meeting then adjourned.

The association again met at 2.30 p.m. The President read his address, of which the following is a brief abstract, after which the meeting resolved itself into sections:

After an introduction in which he referred to the manner in which the Association had been established immediately after confederation, and to the great good that resulted from these friendly meetings, he referred to the varying death rate in the Dominion as revealed by the last published volume of the census. In Ontario the death rate was 11.81 per 1,000, in British Columbia, 20.38, in Quebec, 19.07. Thus, Ontario, with a population 600,000 greater than Quebec, had actually 3,000 less deaths per annum, the figures being, Quebec, 25,930; Ontario, 22,727. This was due he found to the great mortality among children in this Province, the number of deaths from 1 to 11 years being more than sufficient to account for the difference. The figures show that in the Province of Quebec children between the above ages to the number of 16,142 die, a majority of 1,973 being boys, while in Ontario the number is 10,471, with a majority of 973 boys, the difference in favor of Ontario being 5,671.

Each child was valued at $40 to the state by good authority, thus a heavy infantile death rate was an enormous loss, and it could be greatly reduced, as the diseases most fatal, such as smallpox, measles, scarlet fever, typhoid and typhus fevers, could be prevented or confined within narrow limits by proper precautions.

The importance of a bureau of vital statistics was also touched on. There were 3,567 physicians

in the Dominion, with about 800 students; while in the United States about 4,000 physicians were produced a year, and there were 90,000 doctors. He claimed that the average standard of the profession in Canada was equal to any in the world. The necessity of a high standard for students, so that uneducated men could be kept out of the profession, was pointed out. With regard to female medical education, Dr. Sullivan spoke in rather jocular, but at the same time friendly terms, declaring his belief that the presence of women in the profession would raise the standard, not lower it. With regard to the subject of medical service upon ocean steamers, if it was true that the British Act required that the surgeons be shipped only in Europe, then they should get the Act amended, as Canadians ought to have some of these appointments. Great need for reform was said to exist, and a bill was now before the American Congress requiring an extra physician on all ships carrying 600 people beside the crew. Nurses and hospitals were also demanded, and as the mortality was as high as 70.6 per 1,000, there appeared to be good grounds for such demands. Allusion was made to the researches now going on in regard to disease and to the germ theories, and particularly to the announcement that "the dread scourge cholera" was the result of a microbe, also to the inoculation for yellow fever, by Pasteur's method, which had been followed in Brazil with such good results that out of 450 foreigners inoculated with it, less than two per cent. died, while among the uninoculated the death rate was 30 or 40 per cent. He closed by referring to the fact that medicine was every year being held in higher estimation, and it was the duty of all medical men by deep study and research to keep up the standard of the profession. He also referred to the grand opportunity they would enjoy owing to the presence of the British Association in the city.

Medical Section.

The first paper on the programme was "Puerperal Septicæmia," by Dr. Campbell, of Seaforth.

Dr. Sheard asked if Dr. Campbell had made any pathological investigations. He said cases occurred where the autopsy showed no lesions of the uterine tract.

Dr. A. Wright asked if the writer had discovered any other causes aside from laceration. He did not think it could be shown that the lacerations were the cause of the absorption.

Dr. Smith alluded to the identity of this disease with surgical fever, and advised disinfection of the hands and other antiseptic precautions.

Dr. Brodie (Detroit) thought in many cases he could predict before confinement that puerperal fever would follow. There was in some cases an erysipelatous element before birth.

Dr. Patterson thought puerperal fever and septicæmia were identical. It arises occasionally from atmospheric causes, without any other known source.

Dr. Mullin said that in the majority of cases he thought it due to decomposition of clots or shreds within the uterus. He did not think erysipelas was the potent cause it is sometimes represented to be.

Dr. McKay thought the poison might be generated in a debilitated system through imperfect resolution.

Dr. Campbell, in reply, thought the poison in his case originated entirely within—autogenetic.

The Chairman remarked upon the close alliance of erysipelas and puerperal fever.

Dr. Dupuis read a paper on "Nostrums and Medical Advertising."

Dr. Bray referred to the efforts that the Medical Council in Ontario had already put forth, and he hoped that the Councils in both Ontario and Quebec would be supported by the general profession.

Dr. Day said they were going to the Legislature to obtain power to strike from the register any member who should demean himself by unprofessional conduct.

In the Evening Session, Dr. R. MacDonnell exhibited two cases of "Lateral Sclerosis."

Dr. Osler remarked upon the probability of local focus being present in nearly all cases. He described cases of difficulty of diagnosis from caries of vertebræ.

Dr. Harrison of Selkirk read a paper on "Cerebro-Spinal Meningitis," describing several cases which had occurred in his neighborhood. He had alluded to a peculiar form of fever in a paper before this Association two years ago. He now considered that they properly belonged to the category of cerebro-spinal fever. The disease had occurred both in children and in adults.

Dr. R. P. Howard said the disease was rare in this country. In some few localities, as Sarnia, for instance, it is often seen. Its true pathology, and the explanation of these outbreaks would be interesting.

Dr. Bray had seen one epidemic of this fever in his district. The poor, and more particularly colored people were attacked. It was very fatal.

Dr. Geo. Ross took exception to arguments concerning the nature of the disease described, unless substantiated by *post-mortem* examinations. Tubercular disease of the nervous centres will often perfectly resemble the genuine cerebro-spinal fever.

In reply, Dr. Harrison said he treated his cases with bromide and iodide of potassium. The cases he had been describing occurred within a radius of six miles; the shortest lasted four weeks, the longest from 10 to 12 weeks. There was not always hyperæsthesia.

Dr. F. W. Campbell said the cases he saw in the epidemic 10 years ago were amongst the well-to-do.

Opisthotonos was generally present, then remittent and intermittent types of fever. Large doses of quinine did harm.

Dr. Osler said that the diagnosis of cerebro-spinal meningitis must be received with great caution. Of four cases submitted to him for *post mortem* examination only one showed a true inflammation of the meninges.

Dr. Mullin said that the cases observed in Hamilton occurred within four months. Isolated cases seen since were probably typhoid.

Dr. Lett, of Guelph, read a paper on "The Opium Habit and its Treatment," describing its ill results and the treatment which he found most beneficial.

Dr. Pickup enquired as to the value of coca leaves in the treatment. Dr. Lett replied that no substitute or antidote could be considered reliable.

Dr. H. Howard said that he never saw an opium-eater who had not been previously a drinker. He recommended gradual diminution of the dose of opium together with supporting treatment.

Dr. R. P. Howard next read a paper on "Some Varieties of Dyspnœa met with in Bright's Disease," referring especially to Cheyne-Stokes' respiration.

Dr. Geo. Ross described two cases bearing upon the case. The first was an elderly gentlemen, suffering from spasmodic asthma. Examination of the urine showed the existence of Bright's disease. Subsequently there was typical Cheyne-Stokes' breathing, which continued during three or four months. The second case was a lady who had long suffered from asthma, but its dependence on Bright's disease was overlooked. A peculiar feature of her case was the sudden development, during these attacks, of pulmonary congestion, as shown by universal rales and bright blood in the sputa.

Dr. Osler referred to Cheyne-Stokes' breathing in a little girl one year old. He examined the urine, but found nothing. It passed off, and the child is now in its usual health.

Dr. Howard had never observed congestive symptoms. He also suggested that the child mentioned by Dr. Osler should be watched still, as the disease may develope. Frequent examination of the urine was absolutely necessary to make a real diagnosis. As regards treatment, he limited himself to treating the disease itself, as usual, with diaphoretics, vapor baths, etc. Sometimes nitroglycerine was useful.

Dr. W. Gardner, of Montreal, then read a paper on "Common Errors in Gynæcological Practice." He stated that the slighter forms of pelvic peritonitis and cellulitis were often not recognized. In regard to pessaries much misconception obtained. Some practitioners had unbounded faith in them, while others, of equally small experience, decried them as of little or no value. He thought that while pessaries and other therapeutic agents were often of the greatest value in the treatment of displacements, such affections when chronic, were rarely completely cured. Constitutional treatment in addition to appropriate local treatment was often overlooked.

Dr. Trenholme did not agree in regard to the great frequency of chronic pelvic inflammations or their influence on uterine affections. He also approved of the use of pessaries in displacements.

Dr. Heywood Smith, of London, Eng., endorsed most of the author's view, but believed that perimetric hæmatocele was the starting point of many cases of pelvic inflammation.

In reply to Dr. Brown, of Acton Vale, Que., Dr. Gardner said that he believed in the efficacy of hot water vaginal douches in the treatment of chronic pelvic inflammations.

Dr. H. Howard read a paper entitled "Materia Cogitans," giving his views on the relation between thought and brain-matter, after which the section adjourned.

Surgical Section.

The first paper was presented by Dr. Blackader, on "Case of Congenital Lipoma of the Foot." The enlargement which was noticed at birth, had increased in spite of continual elastic pressure by Martin's bandage. At the age of fourteen months the hypertrophied toes and tumor were removed by Dr. Roddick, and the wound healed kindly. Reference was made to the history of similar cases, their etiology and pathology, and to the views of Dr. Busey, of Washington, who referred the changes to congenital defect or disease of the lymphatic system.

Dr. Osler referred to a case in which there was congenital and progressive enlargement of the right upper extremity, the bones, muscles, etc., all being enlarged. In this case the palm of the hand was especially enlarged, owing to an increase in the amount of fat.

Dr. McGraw, of Detroit, mentioned a case which he had seen in Langenbeck's clinic in 1861, where there was enlargement of the left lower extremity and left side of pelvis. There was simple hypertrophy, uncomplicated with any tumor, involving all the tissues of the limb, which became so large that the girl was unable to walk.

Dr. Fulton, of Toronto, then read his paper on the "Thoraco-plastic Operation of Estlander." This paper will be published in a future number of the Lancet.

Dr. Hingston thought the question of operating in empyema a difficult one, for we seldom find two cases exactly alike. Estlander's operation would be more successful if portions of more ribs, but to a less extent, were excised. He recommended the thorough washing out of the chest with carbolic lotion and the free exposure of the whole surface as the best methods of treatment.

Dr. Kerr gave an account of a case which he had seen in consultation, which might be benefited by this operation. A free incision had been made, the patient sent to the sea-side and the general health attended to, and the discharge had diminished. He thought the curette might be used for the eradication of the pyogenic membrane.

Dr. Holmes thought that if cases of empyema were treated earlier, less disastrous results might ensue. Slow closure is often due to the fact that pus has remained in the cavity a long time, and by its presence interfered with the vitality or tone of the membrane.

Dr. Roddick alluded to the various methods of treating empyema in the Montreal General Hospital. In chronic cases the rule now is to excise an inch or more of one rib, if necessary, and drain by means of a tube of large calibre, antiseptic precautions being taken throughout.

Dr. Sherriff, of Huntingdon, then read a paper on "Hæmorrhoids," in which he had pursued with success the treatment of crushing, as advised by Pollock in Braithwaite for January, 1883, and as carried out by him in his wards at St. George's Hospital, London.

Drs. Sloane, Hingston, Tye and Roddick made remarks upon the paper.

In the evening session, Dr. Fenwick, of Montreal, read a paper on "Abscess of Abdominal Parietes extending from Meckel's Diverticulum." from which a large concretion escaped, composed of fæces incrusted with phosphate of lime.

Dr. R. P. Howard referred to a case he had recently seen, of acute inflammation and suppuration about the umbilical region; poultices were applied and in a few days a semi-solid concretion about the size of a bean escaped, and the patient said that five such had been passed. The patient recovered. Dr. Howard thought there was connection with the bowel, probably through the umbilical vesicle which had remained patulous.

Dr. King, of Hull, Eng., mentioned a species of abscess which began by a hard, deep swelling, situated so deeply that it was difficult to make out whether it was intra or extra-abdominal. They began in the muscles, sank towards the inguinal region and there appeared as carbuncular swellings.

Mr. Lawson Tait suggested that the calculus found by Dr. Fenwick should be cut, for he thought it was made up of cholesterin, and therefore hepatic in origin. He advised an immediate opening of the abdomen in all cases where the matter discharged from a sinus in the abdominal walls has a fæcal odor.

Dr. Shepherd, of Montreal, read a paper on "Ligature of Anterior Tibial Artery in a Case of Compound Fracture of the Leg," and showed the patient. Drs. Fenwick, Sullivan, Fulton, Giles, Girdwood, Holmes and Proudfoot took part in the discussion, after which Dr. Gardiner, of London, Ont., read a paper on "Burns and their Results."

Dr. Stewart, of Montreal, then read an interesting paper on the "Action and Uses of Naphthalin." As an antiseptic it compares very favorably with iodoform. It is especially suitable in chronic ulcers and burns which have no tendency to heal. Iodoform is apt to induce a certain sponginess of a granulating surface, and after a certain stage in the treatment, does more harm than good. Naphthalin can be used throughout the treatment of a sore, and in place of retarding the healing after rendering the tissues antiseptic, it actually promotes it. It can be used either in a finely powdered form or in gauze.

Dr. Shepherd agreed with Dr. Stewart that iodoform was useless in granulating wounds; in such cases he used Balsam of Peru or naphthalin, but considered the balsam best as a stimulant.

Dr. Roddick used it in old burns and chronic ulcers with satisfaction, combined with boracic acid to facilitate the dusting of it. In empyema or large abscesses, he used naphthalized jute as an outside dressing.

Dr. Reeve, of Toronto, read a valuable paper on "Trephining the Mastoid" (fifty cases).

SECOND DAY.—GENERAL MEETING.

After the reading of the minutes, Dr. Mullin presented the report on Ethics, which was adopted.

The President then called upon Mr. Lawson Tait to deliver his address on "Abdominal Surgery," which will be found in this number.

MEDICAL SECTION.

Dr. Geo. Ross showed two specimens of Aneurism of the Thoracic Aorta, one obtained that day, the other two weeks previously. In one case, the physical sign of tracheal tugging had been present; in the other, absent. In both cases, this sign had been of great service in diagnosing the aneurism.

Dr. Worthington, of Clinton, read a paper on "Some cases of Diabetes Insipidus," one of which was complicated with exophthalmic goitre.

Dr. Harley, of London, made some remarks. He objected to the term Diabetes Insipidus, and preferred the term Polyuria. It may sometimes be connected with congestion of the kidneys, but is often present in chronic atrophy. In one of Dr. Worthington's cases twenty-five pints were passed in 24 hours. What is the exciting cause? Very often this cannot be traced. In saccharine diabetes, the sugar is the essence of the disease, and the quantity of water is only for the purpose of eliminating the sugar. The treatment of polyuria is very unsatisfactory. The only satisfactory management is the care of the patient's general hygiene.

Mr. Mills mentioned a case he had observed

under Dr. Stephen McKenzie. A lady had been in the habit of eating great quantities of sugar, which produced diabetes mellitus.

Dr. Sloane, of Blyth, instanced a case of polyuria where the amount of urine was very large and the specific gravity 1003. Iron was of no use. Bromide of potassium and ergot seemed to do good.

Dr. Sheard spoke of certain cases of diabetes mellitus, in which he had opportunities of examining the brain centres. Microscopical changes were found.

Dr. Geo. Ross said that Dr. G. Johnson, of London, had proved the existence of changed structure in the great semilunar ganglia of the sympathetic. He also referred to a case of polyuria in a woman, the subject of secondary cancer of the liver. He thought the co-existence of exophthalmic goitre of great interest in showing, in the same individual, disorder of another portion of the great sympathetic system.

Dr. T. Wesley Mills showed an improved method of making a quantitative test for sugar in the urine.

Dr. O. C. Brown, of Acton Vale, read a paper on "Impaction of the Pregnant Uterus in the Pelvis as a Cause of Abortion," giving cases which had occurred in his practice and which he had successfully treated.

Dr. Playter read a paper on "The Relation of the Medical Profession to the Public."

Dr. Gurd showed a patient in whom a cardiac murmur could be heard in the mouth and at a short distance from it, transmitted from the chest. The murmur was mitral systolic.

SURGICAL SECTION.

This section met at 3.30 p.m. Dr. Major, of Montreal, read a paper on "Buccal Breathing."

Dr. Elsberg, of New York, made a few remarks in support of the views held by Dr. Major.

Dr. Proudfoot, of Montreal, read a paper on "Paracentesis of the Membrani Tympani."

Dr. Reed, of Montreal, exhibited an interesting case of "Inguinal Hernia." The scrotum was of immense size. The hernia occurred twelve years ago, and is now irreducible.

Dr. Sutherland showed a case of "Keloid." The patches were situated on the chest, right gluteal region, and right shoulder.

Dr. Oldright, of Toronto, read a paper on "Myxo-Sarcoma," a sequel to the paper read last year.

Dr. Shepherd, of Montreal, read a paper on "An obscure case of Femoro-Popliteal Aneurism," in which amputation was performed, and showed the specimen.

Dr. Gardner, of Montreal, read a paper on "Uterine Myoma." He had operated successfully on four cases.

Dr. Strange, of Toronto, said that he never incised the cervix, but trusted to slow and gradual dilatation. He used free irrigation of the uterus after operating to wash away the debris.

Dr. Heywood Smith, of London, Eng., thought such method of operating was not applicable in all cases, especially in nulliparous women, in whom the parts are of necessity small. He thought that any incision made in the cervix should be allowed to heal before proceeding to operate.

Dr. Buller, of Montreal, read an interesting paper on "Jequirity in Granular Ophthalmia," and exhibited a rabbit on which he had been experimenting with this remedy. Dr. Reeve, of Toronto, gave his experience of its use.

Dr. Elsberg exhibited a new and improved forceps for removing foreign bodies from the throat.

Dr. Osler gave an abstract of his paper on "Pneumonia as a Contagious Disease."

The following officers were elected for the ensuing year:—*President*, Dr. Osler, Montreal; *General Secretary*, Dr. James Stewart, Montreal; *Treasurer*, Dr. Sheard, Toronto; *Vice-Presidents*, Ontario, Dr. Bray, Chatham; Quebec, Dr. Geo. Ross, Montreal; New Brunswick, Dr. Allison, St. John; Nova Scotia, Dr. Fraser, Windsor; Manitoba, Dr. Whiteford, Winnipeg; *Local Secretaries*, Ontario, Dr. Burt, Paris; Quebec, Dr. J. Bell, Montreal; New Brunswick, Dr. Walker, St. John; Nova Scotia, Dr. Almon, Jr., Halifax; Manitoba, Dr. Mewburn, Winnipeg.

COMMITTEES.—*Publication*, Drs, Kennedy, Montreal; Fulton, Toronto; W. H. B. Aikins, Toronto. *Medicine*—Drs. Cameron, Toronto; F. W. Campbell, Montreal; Saunders, Kingston. *Surgery*—Drs. Kerr, Winnipeg; Kains, St. Thomas; Waugh, London. *Obstetrics*—Drs. Holmes, Chatham; McKay, Woodstock; Campbell, Seaforth. *Therapeutics*—Drs. Oliver, Kingston; Sloane, Blyth; Tye, Chatham. *Necrology*—Drs. Fulton, Toronto; Graham, Toronto; Cameron, Montreal. *Education*—Drs. Pyne, Sheard and A. H. Wright, Toronto; Botsford and Allison, St. John; Arnott, London. *Public Health*—Drs. Yeomans, Mount Forest; Grant, Ottawa; Harding, St. John; Robillard, Ottawa; Larocque, Montreal; Botsford, St. John; Playter, Ottawa; Drs. Bryce, Covernton and Oldright, Toronto; Hon. Dr. Parker, Halifax; Kittson, Winnipeg. *Arrangements*—Drs. Ferguson, Kerr, Whiteford, Mewburn, Patterson, O'Donnell, Codd, Lynch, and Jones, with power to add to their number.

After formal votes of thanks to officers of the Association and others, the Association adjourned to meet in Winnipeg on or about the third Tuesday in August, 1885.

BRANT COUNTY MEDICAL ASSOCIATION.

The Annual Meeting of the Brant County Medical Association was held in Brantford, on Tuesday,

2nd September. The minutes of last meeting were read and confirmed. Dr. Winskell read an interesting paper on "Uræmic Convulsions," which was well received and discussed.

This being the Annual Meeting, the election of officers took place for the ensuing year, and resulted as follows, viz.: Dr. Marquis, Mount Pleasant, President; Dr. Winskell, Brantford, Vice-President; Dr. Fairchild, Mount Vernon, Secretary-Treasurer.

The term of office of Dr. McCargow, the representative of the Erie and Niagara division in the Ontario Medical Council having nearly expired, Dr. Henwood, the former representative, paid a just tribute to the zeal with which Dr. McCargow had performed his duties while a member of the Council.

It was then moved that Dr. Philip, of Brantford, be the nominee of the Brant Medical Association as the representative of the division in the Ontario Medical Council, which was carried unanimously. In accepting the nomination, Dr. Philip paid a high tribute to the ability of those who had represented the division in the Ontario Council since its inauguration. He dwelt upon several matters which would come before the Council, and said that whether he was elected or not, he should ever feel grateful to his medical brethren in the county of Brant for the confidence reposed in him.

Dr. A. J. Henwood was elected a member of the Association. Dr. Burt, of Paris, was appointed to read a paper at the next meeting, which will be held in Brantford in December. After some routine matters were disposed of, the Association adjourned.

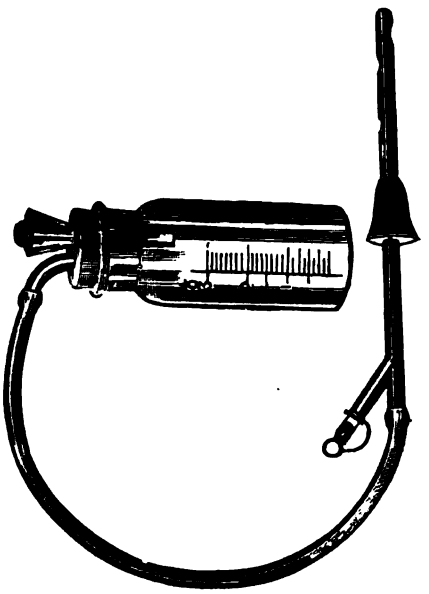
Selected Articles.

APPARATUS FOR ETHERIZATION BY THE RECTUM.

Dr. J. S. Miller of Philadelphia read a paper before the County Medical Society (*Medical News*) in which he reported four cases of etherization by the rectum, and exhibited a form of apparatus shown in the cut. It consists simply of a water-bath, a graduated bottle provided with a funnel and valve for pouring in the ether, and a supply-pipe for conducting the vapor to the rectum. This tube terminates in a straight recurrent catheter, the exhaust channel of which is controlled by a valve. The catheter is furthermore provided with a movable collar for pressure against the anus—it having been found that the vapor tends to escape by the side of the tube.

Some question having arisen as to whether the vapor really does pass the ileo-cæcal valve, I deemed this a subject for legitimate vivisection, and, etherizing a cat per rectum, opened the abdominal cavity, and noted that the small intestine was as greatly distended as the large.

In this method of etherization, the most obvious advantages are as follows:



1. Dyspnœa is avoided, and the patient is saved from the anxiety due to a sense of impending suffocation.

2. There is avoided the danger of simultaneous irritation of the superior laryngeal and pneumogastric nerves at the periphery—these irritations neutralizing each other in the respiratory centre, and suspending respiration entirely.

3. The danger of asphyxia is lessened—the patient not being drowned in his own mucus, and the integrity of the pulmonary mucous membrane as an organ of gas exchange is preserved. Of course, some vapor finds itself in the lungs, and acts there as a local irritant—elimination being by that channel. But the quantity is not great, and does not constitute a source of danger. In the cases reported, the increase in secretion was too trifling for discovery.

4. The stage of excitation is therefore not prolonged by the struggles for breath. In general, it may be said that the delirium of any alcoholic intoxication is a pleasant and good-natured one, unless the patient is crossed—as he certainly feels himself to be when a wet towel is pressed over his face.

5. Nourishment may be taken before operation to sustain the powers of life, and lessen the dangers from shock.

6. Return to consciousness is prompt—this stage not being prolonged by carbonic acid poisoning.

7. The anæsthetic seems as readily suspended as by the ordinary method—the bowel being promptly emptied by gentle massage.

8. Economy in ether is an advantage hardly to be mentioned with more important considerations.

The more obvious disadvantages are:

1. The exposure of person required—the abdomen being necessarily under observation, even if the catheter be inserted under cover.

2. More judgment and experience are required in the administration, than by the ordinary method—over-boiling in the apparatus, and too much distention, being both painful and highly dangerous. The warning to cease is sudden, and must be immediately obeyed.

3. Just as the other mode is inconvenient in oral surgery, so in perineal operations is the apparatus needed for this method, in the way.

4. In abdominal surgery, or if there be marked intestinal lesion, this mode is contra-indicated.

5. The inapplicability in cases of accident and emergency, when time cannot be allowed to prepare the bowel, has already been mentioned.

6. Diarrhœa has been noted in seven out of the thirty-seven cases on record, though in none of mine.

I believe this sequel is due to pre-existing intestinal lesion, to the lack of preparation, to a too great distention of the bowel, or to the accidental introduction of ether in liquid form. Furthermore, my method has differed from that of other experimenters in this respect, that instead of allowing the vapor to remain indefinitely, I secured a constant change by using a recurrent catheter, and introducing a certain quantity, or permitting it to escape, as indicated.

Other points of advantage and disadvantage may occur in later experience, and to other observers, and new dangers may be discovered. But I am convinced that this method is worthy of further trial, and will find its place in surgery, fulfilling its own, though not *all*, indications. Like all else in therapeutics, it must pass through the stages of bungling use, condemnation, and revival.

PYO-SALPINX AND HYDRO-SALPINX.

Dr. Wm. Goodell exhibited specimens of the above at the Obstetrical Society of Philadelphia, June 6th, 1884.

In the former case the lady was unmarried, and had suffered from pelvic pains and menorrhagia for several years. Last autumn a tumor was discovered by her physician, who deemed it a fibroid of the womb. Early this year her sufferings became so great that she took to her bed. Very large doses of morphia were needed, and septic symptoms now set in. After she had been in bed for several weeks, Dr. Goodell was called in to see her. The tenderness of the abdomen was so great that the examination was made under ether. Even then the diagnosis was obscure because she flinched and her recti muscles became tense whenever the abdominal wall was pressed upon. A cyst was discovered, but of what nature it was impossible to determine. Dr. Goodell operated on her at his private hospital. The womb was studded with small fibroid nodules, posteriorly it had an outgrowth as large as a small egg. Closely adherent to the womb, to the pelvic fascia and to the intestines, was a thick-walled cyst of the left ovary, as large as the largest orange. The corresponding oviduct was very thick and enlarged to the size of a small sausage. It and the cyst were filled with a very dark purulent fluid, although there was no communication between them. The lower end of the cyst had become necrosed, and was so thinned out that it would very soon have given way at that point. On account of the presence of fibroids in the womb, the right ovary was also removed. Attached to the fimbriæ of the oviduct were three very beautiful pedunculated vesicles; while two others not yet pedunculated lay in the stroma of the broad ligament. The recovery of the lady was uninterrupted.

In the case of hydro-salpinx, the patient was a widow aged 37, who had been sent to him in order to have her ovaries removed. Severe pains began a week before the menstrual flow, culminating during the flow and continuing one week longer, then fading gradually away. For three weeks out of every month she was confined more or less to the recumbent posture, and wholly so during the menstrual week. A tear of the cervix and one of the perinæum had been well repaired by two surgeons, but with no improvement. Dr. Goodell wished her at first to try the rest treatment with massage, electricity and graded muscular movements, for he had repeatedly cured cases of this kind through such a mode of treatment. She was, however, too poor to take this treatment privately, and was therefore urgent to have her ovaries removed. The operation was performed fifteen days ago, and she is now doing very well indeed. The ovaries as exhibited were much enlarged, and showed marked follicular degeneration. From this condition Dr. Goodell thought that nothing short of the operation would have cured her. Attached to one oviduct was a delicate vesicle with a thread-like stem of over an inch in length. In view of the frequency with which they are found, he could not but think that these vesicles played some role in the economy, and that they had sometimes a pathological bearing. He had on several occasions met with small post-uterine cysts which burst either spontaneously or under the pressure of an ordinary vaginal examination. Taking advantage of this fact, he had quite recently burst one designedly by bi-manual pressure. Such delicate cysts, and also those very movable ones which remained small without increase in bulk, he was disposed to attribute to these vesicles. After bursting

these cysts sometimes refill. One he had known to burst and refill at least six times before it disappeared. New small ovarian cysts had, in his experience, thick walls, and further, they rarely remain small any length of time. Dermoid cysts, on the other hand, often remain stationary for years, but they were generally not very movable, and they also had thick walls.

Dr. Albert H. Smith had found these cases of pyosalpinx very difficult of diagnosis. He had been present at an operation by Knowlsley Thornton upon a case in which the lesion was double and both tubes and ovaries were removed. Rupture had occurred previously, and had been followed by peritonitis. The patient recovered.

Dr. B. F. Baer inquired if Dr. Goodell would recommend rupture of cysts arising from the carotids of morgagni.

Dr. Goodell would consider it good service for the purpose of preventing the further growth of the cyst. He had always found the fluid in such cases to be unirritating.

Dr. Albert H. Smith remarked that Schroeder holds that the fluid of an ovarian cyst is not noxious to the peritonæum. He makes no effort to secure the peritoneal cavity from its ingress during the operation, and yet his statistics show at least fair success.

In response to a question by Dr. C. Meigs Wilson, Dr. Goodell stated that the dressing of the wound after the operation was glycerole of carbolic acid with the Lister gauze.

Dr. Goodell also gave the following history of a case of hysterectomy. The woman was unmarried, aged 47. Her monthly fluxes began to be free in 1867. A year ago they became so exhausting that she could not pursue her trade as a seamstress. On April 30 she consulted Dr. Goodell, who found the whole abdomen filled with multiple fibroids of the womb. The cervix had disappeared and the os uteri lay so high up that it was not possible to introduce the sound. The operation was performed at the Hospital of the University of Pennsylvania, on May 22, on the same day with the preceding case. One outgrowth as large as the two fists contained a cavity filled with cheesy matter, and was so adherent to the abdominal wall and intestines as to need the knife for its release. It was possibly the right ovary, but he was by no means certain. Koeberle's wire-clamp was passed around what corresponded to the neck of the womb, but it was as large as his arm above the elbow. The woman's recovery thus far has been uninterrupted. The temperature reached 100° but once. The clamp fell off on the 16th day, leaving a very deep funnel-shaped pit. He had intended to exhibit the specimen, but it was too bulky to carry and also had become quite offensive. In this case had he been able to reach the ovaries or to have discovered them he would have removed them in preference to performing hysterectomy; but the firm adhesions prevented the rotation or the lifting up of the tumor, hence the ovaries were inaccessible. Sometimes even when the uterine fibroid can be lifted out of the wound and the ovaries reached, these organs are so embedded in the fibroid, or so drawn out in ribbon-form on the surface of the tumor as to make their complete removal impossible. When, however, the ovaries can be removed with safety, the operation is a most promising one, as he could attest from several most successful cases.

DIAGNOSTIC SYMPTOMS IN THE DISEASES OF CHILDREN.—Politzer gives the following concerning the value of certain symptoms in children's diseases (*Deutsche Med. Zeitung*, May 19, 1884): 1. The symptom of a strongly-marked nasal tone in crying points to the probable existence of a retropharyngeal abscess. 2. A loud and very long-continued expiratory sound, with normal inspiration and the absence of dyspnœa, is significant of chorea major. Sometimes this sound resembles the bellowing of an animal, and may continue for a long time as the only symptom of chorea. 3. A thoracic, sighing inspiration indicates cardiac weakness. This is one of the first symptoms, appearing before cyanosis or pallor of the face, thready pulse, coldness of the extremities, or the other well-recognized signs of weak heart. 4. A marked diaphragmatic expiration, accompanied with a fine, high-pitched whistling, points to bronchial asthma. 5. A marked interval between the end of expiration, and the beginning of inspiration renders the diagnosis of catarrhal laryngitis without exudation probable. 6. There is no special significance in the loud, sort of bleating expiratory sound sometimes observed in infants during the first months of life. It seems to depend upon a modified innervation within physiological limits, and resembles the want of rhythm in the cardiac movements occasionly met with in the early years of childhood.

The following symptoms are indications of cerebral diseases: 1. A peculiar drowsiness, continuing for several days, unaccompanied by fever or other disturbance, is indicative of basilar meningitis. This is a more valuable sign than headache, vomiting, or a slow, irregular pulse, since the latter may occur in various extracranial diseases. 2. A tense, elevated anterior fontanelle points to intracranial effusion. If it be very prominent, resistant to pressure, and without a sign of pulsation, there is almost certainly an intermeningeal hemorrhage. A deeply-sunken fontanelle indicates inanition and a diminished volume of blood. 3. Very slow movements of the eyes, followed by fixity in one position, a vacant stare, and a peculiar lazy closing of the lids are signs of a beginning basilar meningitis. The character of the cry is of value sometimes in the diagnosis. 1. A fit of shrill crying, lasting for

two or three minutes, accompanied by an expression of fear in the face, and coming on regularly an hour or an hour and a half after the child has gone to sleep, is the expression of night-terrors. Quinine, given in a rather large dose one or two hours before bed-time, is an effectual remedy against this trouble. 2. Periodical crying-spells, of five or ten minutes' duration, coming on sometimes during the day but more frequently only at night, point to cramps in the bladder, provided that we can exclude intestinal or gastric colic. This is speedily cured by emulsion of lycopodium with or without belladonna. 3. Crying while at stool and an evident dread of the act of defecation are signs pointing to fissure of the anus. 4. Hard, continuous crying, expressive of severe pain, together with frequent putting of the hands to the head or rolling of the head in the pillow, are evidences of otitis media or pain in the ear from some other cause. 5. When for days and weeks the child cries on being moved, and when there is also profuse sweating and an elevated temperature, the disease is rickets. 6. Frequent crying, with habitual sleeplessness during the first two years of life, are found in anæmic and poorly-nourished children, or in those with congenital syphilis. He also recounts some other single symptoms which aid in diagnosis. 1. The peculiar physiognomy of children suffering from congenital syphilis. The sinking in of the root of the nose, the sallow complexion, the scanty eyelashes, the yellowish edges of the eyelids, and the rhagades on the underlip are characteristic of hereditary syphilis. 2. A falling together of the alæ nasi, and an absence of all motion in them during inspiration, point to hypertrophy of the tonsils. 3. A weakness and loss of motion out of all proportion to the gravity or duration of the accompanying illness should raise a suspicion of infantile paralysis. 4. A partial loss of hearing after a sickness is often due to a circumscribed meningitis at the base of the fourth ventricle. 5. Depression of the mental faculties occurring after a severe infectious disease is frequently indicative of a beginning acquired idiocy. Strychnine exerts a favorable influence in these cases. 6. Retarded ossification of the skull may imply rachitis. 7. A stiff carriage of children in walking, standing, sitting down, or stooping, is observed in commencing Pott's disease. In children who do not walk there is a painful contraction of the features when they are lifted up or set down. 8. Constant vomiting of all ingesta, lasting for several weeks, in children with large heads but closed fontanelles, is a sign that an acute hydrocephalus is engrafted upon the chronic condition.

Hodgkin's Disease and Interstitial Hepatitis.—Prof. Da Costa has under his care a patient who has had Hodgkin's disease for fifteen years. The disease has been kept in check by living in a yacht, supplementary to treatment. He strongly urges arsenic, increased in dose until constitutional symptoms are manifested, and kept there, as the best medicinal treatment.

Prof. Da Costa also teaches that in the early stages (before contraction) of interstitial hepatitis (cirrhosis), a cure may be effected, but that after contraction nobody ever recovered. He has seen the disease in women who did not drink, and the worst case he ever had was in a boy four years old, in which the diagnosis was confirmed at the autopsy. Inherited syphilis is a cause of it. In the early stages the remedies are leeches, sulphate of magnesium, cream of tartar, iodide of potassium. —*Col. and Clin. Record.*

New Operation for Cancer of the Rectum. — At a meeting of the Société de Médicine of Lyons in May, (*Courier of Medicine*) M. Maurice Pollosson read a paper in which he proposed a modification of the operations hitherto practised for the relief or cure of cancer of the rectum. The establishment of an artificial anus as a palliative measure has long been recommended and practised. By this means the irritant effect of the fecal matter upon the cancerous mass is prevented; the patient is relieved from much suffering, and the cancerous mass being freed from irritation, grows less rapidly.

M. Pollosson adopts this procedure in a modified form as a preliminary step in his plan for radical treatment of this affection. He selects the left iliac region as the site for the operation, because there more readily than in the lumbar region can he close up the lower segment of the bowel, which he regards as a point of essential importance in the operation. This he does by invaginating some millimetres of the lower free end, after dividing the bowel clean across, and obliterating the opening completely by means of five or six cat-gut sutures which thus bring into close apposition the serous surfaces. The artificial anus is completed by suturing it carefully into the wound.

After the patient has recovered from this operation, he proposes to extirpate the cancerous mass which, by virtue of the preliminary operation, is practically removed from its relations as a part of the digestive tract and converted into a pelvic tumor. Operating under the conditions so brought about, it is possible to apply the principles of antiseptic surgery much more thoroughly and efficiently than in the condition existing without such a preliminary operation.

In most cases he believes that it would be advisable to allow the patient to recover from the effects of the first operation before performing the second, though he thinks that circumstances might be such as to make it better to go on at once and extirpate the cancerous mass at once after establishing the artificial anus.

EPILATION IN PARASITIC DISEASES.—Although this plan has the sanction of age and custom, it bids fair to disappear as a method of treatment. Dr. Shoemaker, of Philadelphia, in an article which appeared in the July number of the Journal of Cutaneous and Venereal Diseases, gives his opinion of this method, and his reasons for discarding it bear the impress of logic and common sense. In the first place as he states, the parasite is not eliminated by epilation, whereas thorough treatment will completely eradicate it, and when it has disappeared the hairs and their follicles will again assume a healthy and normal state. In the next place, he very justly claims that it is well-nigh impossible to epilate diseased hairs, from the fact that they are brittle, break off easily, and, even if successfully taken out, only aggravate the diseased condition of the follicles. Cutting off the hair or shaving it is also a very poor method; for when the applications are rubbed in the scalp the stubby hairs are disturbed to such an extent as to increase the irritation about the follicles. The proper method of treatment is to use parasiticides and avoid all conditions which tend to nourish the parasite. One of the best methods of avoiding the latter is to discard water altogether. Applying water to the skin only renders it in a better condition for the nourishment of a parasite which has lodged there. —*Med. Review.*

PHOSPHORUS IN TUBERCULAR DISEASE.—I can quite understand the remarkable success that has attended Dr. Greenway's treatment of tubercular meningitis by phosphorus. Phosphorus is a nutrient for exhausted nerve substance, and it certainly seems a powerful absorbent of recent exudations. Phosphorated oil has even been said to promote the absorption of a cataract if it be rubbed over the eyebrow. In meningitis we have an exudation of yellow lymph at the base of the brain, beneath the arachnoid, and in the web of the pia mater. Prior to absorption lymph undergoes a fatty transformation or solution, and this condition is speedily brought about by phosphorus, for the drug is well known to bring about fatty change in organs. Pathological knowledge therefore seems to point to it as a fitting medicine.

I have employed phosphorus as well as the phosphites of potash and soda, and under the influence of these preparations have seen pleuritic thickenings melt away. Old standing consolidations of the lung that had existed for one, two and three months, I have seen at once begin to move and disperse as soon as the hypophosphite of potash was given; and cases that have appeared to myself and others very much like acute tubercle in the lungs have sometimes recovered on the hypophosphites.

I commenced about twenty years ago with phosphorated oil as a medicine, but owing to its nauseous taste I took before long to the use of the hypophosphite salts, which contain phosphorus in a very low state of oxidation; and certainly, in those lung diseases which are of inflammatory exudative origin, and apt to run into phthisis, I know of no remedy to compare with the hypophosphites.

Before the discovery of the tubercle bacillus I had come to the conviction, from observation, that there were cases of lung disease where something seemed most decidedly to stop the way towards recovery by means of drugs given by the stomach. If inflammation be the sole agent that destroys the lung in phthisis, I should regard very few cases as incurable. It is the bacillus that seems to set the phosphorus treatment at defiance, and I notice at Victoria Park Hospital, that just when I find the hypophosphites most helpless, then it is that my clinical assistant finds "lots of bacilli."

A few weeks ago we turned out as cured a case of unmistakeable disease of the upper third of one lung, and in that case no bacilli were found.—J. C. Thorowgood, F.R.C.P., in *Brit. Med. Jour.*

REMEDY FOR RHUS POISONING.—As this is the season when many persons are making excursions into the country, it is to be expected that there will be many who will suffer from poison contracted by contact with the poison oak. Various remedies have been employed to relieve the suffering thus occasioned, but while one remedy is advantageous to some persons it utterly fails with others. Having learned of a great number of cases in which the fluid extract of serpentaria has been used with remarkable success, I thought it would be well to communicate the fact to your journal, as I have never seen it noticed in medical or pharmaceutical journals. It is best applied by placing cloths moistened with the extract upon the affected parts, without any friction. Two or three applications generally effect a cure.—*Am. Jour. of Pharmacy.*

SALICYLIC ACID IN THE TREATMENT OF LUPUS. —I have for some time employed salicylic acid in the form of ointment, as a remedy for eczema of the scalp and impetigo contagiosa in children, with the most satisfactory results, cases that had defied all other treatment yielding rapidly to its agency, and I have been induced to make a further trial of it in other skin affections.

By the kindness of Mr. Rigby, surgeon to the Doncaster Infirmary, I was permitted to employ it in a very bad case of lupus exedens.

The patient, a woman about twenty-five years old, had her face terribly disfigured, the ulceration having destroyed one ala nasi, the whole of the cheek and eyebrow having been involved. She had been in the hospital before, and had improved under treatment with Donovan's solution and a visit to Harrowgate. But on her return, though she was kept under treatment and observation,

fresh tubercles developed, and the parts that had cicatrized soon became again involved, and she was re-admitted to the institution. I first tried an ointment of fifteen grains of the acid to an ounce of cosmoline, which was of no use; I then increased the strength to a drachm, and then to one drachm and a half to the ounce.

The ulcers soon began to heal, no fresh tubercles appeared, the cicatrices became soft and lost their shiny, unhealthy appearance, and the skin of the face is now almost sound. She was previously taking a mixture of Donovan's solution and the liquor ferri dialysati. But as this had been without apparent benefit, I think it fair to give the credit to the external remedy. I have not heard of salicylic acid being employed before in the treatment of this disorder, and its action seems very satisfactory, especially as it does not seem to cause much irritation.—*Brit. Med. Jour.*

Treatment of Fistula in Ano.—Dr. Poingt claims *(Le Courrier Medical)* that any fistula amenable to treatment by the elastic ligature may be cured by simple drainage of the fistulous tract. The drainage tube is to be inserted by means of a stylet passed up the tract from the external opening. At the end of two or three weeks the drainage-tube falls out, after having destroyed the superficial wall of the fistula. A granulating surface of small extent is left, which rapidly heals by cicatrization. The procedure is wholly painless, and the patient may pursue his ordinary avocation during the entire course of treatment. The operation is never followed by any of those serious complications sometimes seen after the cutting operation.—*Southern Clinic.*

The Number Seven. — Hippocrates believed there was "luck in sevens," and he, like Shakespeare, divided the life of man into seven stages, holding that the number seven is the fountain of all the changes in life. For instance, the teeth appear in the seventh month or sooner, and are shed and renewed in the seventh year, when infancy is fully changed into childhood. At twice seven years puberty begins. At three times seven the adolescent faculties are developed, manhood commences, and men become legally competent to complete civil acts. At four times seven man is in full possession of all his strength. At five times seven he is fitted for all the business of the world. At six times seven he becomes wise, if ever. At seven times seven he is in his apogee, and from that time decays. At eight times seven he is in his first climacteric. At nine times seven he is in his last or grand climacteric, and at ten times seven he has approached the normal period of life.

There are some remarkable septenary coincidences in the discharge of physiological functions, and in disease processes. The human female menstruates in four times seven days, and in forty times seven days she gives birth to her child. The period of gestation in animals is, in many if not in all instances, a multiple of seven. In the dog it is nine times seven days; in the cat, eight times seven; in the fox, six times seven. The common hen sits on her eggs three times seven days; the duck and goose, four times seven; the crow, three times seven; the swan, six times seven; the peacock, four times seven; the canary and pigeon, twice seven. Bees hatch out in three times seven days. Fever and ague has a tendency to terminate spontaneously after the 7th, 14th and 21st paroxysms. Relapsing fever is a disease of seven days' duration. Typhoid fever lasts three times seven days. The incubation of measles is twice seven days, and the disease itself lasts seven days—three days of catarrh and four of eruption—before it declines. Scarlet fever and erysipelas occupy seven days. Small-pox requires twice seven days—from the time of the appearance of the primary fever and the full development of the eruption, seven days, and in seven days more the whole crop of pustules has been converted into desiccated scabs. Truly, there is something wonderful about the number seven.—*Med. Age.*

Doctor's Mistakes.—At the recent meeting of the Kentucky State Medical Society, a number of the members grew quite confidential, and related, when in that mood, some experiences which it is not customary to see recorded in the public prints. For instance, Dr. Stone told of a German woman, the mother of three children, whose case was pronounced to be one of simple ascites. Several physicians, among whom was a distinguished professor of surgery, saw the case, and the latter used the sound and speculum to verify his diagnosis, preparatory to the operation which he contemplated performing for the removal of the left ovary. The manipulation excited some contractions of the uterus, during which a large clot of blood was expelled. After these symptoms passed away, an able obstetrician and professor, and an author of national reputation, was called in, with a view to making the diagnosis doubly sure. He, too, examined with sound and speculum, and diagnosed the existence of two tumors, one the enlarged and subinvoluted uterus, the other of doubtful character, probably cystic, developed within the broad ligament. The sound, when withdrawn, as in the previous examinations, was covered with blood, and pains came on soon afterwards. In fifteen minutes, a clot of blood and three pints of water passed from her vagina, and a few hours later the woman gave birth to a six and a half months' child, which lived till morning and died.

Dr. Yandell, of Louisville, related several experiences which, recorded in detail, would make quite as interesting a report as that by Dr. Stone. He

knew of two or three such cases as that reported by the doctor. Prof. Miller and Prof. Baylis diagnosed an abdominal tumor to be ovarian, and not until the woman gave birth to a child did they discover their mistake. Some years afterwards a woman came up from Mobile. She had a tumor. She was a widow. Parvin saw it, Miller saw it, Thomas saw it. All declared it to be a fibroid. In the fall she gave birth to a child. Dr. Y. saw a case four years ago of an enormous tumor pronounced by Parvin, Gross and other eminent men, with himself, to be a fibroid. The woman was put on muriate ofammonia and ergotine. One night, after about three years of such treatment, she was seized with all the symptoms of peritonitis, collapse and shock. She was tapped, and an enormous quantity of fluid was drawn off. The cyst refilled. Dr. Yandell operated on her afterwards for its enucleation, and while the operation was as easy as it was possible to do, the woman died.

Such cases show simply that the wisest and most experienced of us make mistakes.—*Med. Age.*

RECTAL FEEDING AND MEDICATION.—Dr. Wm. Julius Mickle gives some very useful hints in a paper on this subject published in *The Journal of Mental Science.* In using nutrient enemata he advises that : Alcohol should not be added to albuminous food. If necessary, the bowels should previously be cleared out by a simple or aperient clyster, and a daily copious cleansing clyster is required in some instances. The bowels may have to be rested, but we must persevere if the first attempt fails. Where it is apt to return, the patient's best position to receive the enema is on the back or left side. The nozzle or tube should be comfortably warm, so should the food injected. The amount injected may sometimes with advantage be small at first, gradually increasing from 2 to 10 ozs. If the foods are ejected, we may try the plan (Dr. Hine's) of depositing them higher up in the viscus by means of elastic tubing and a funnel. But plugging the anus is often necessary, and has been done in many cases. Conflicting as are the results of experiments on the subject, he concludes that the rectum and colon digest but little, and that, even when inverse peristole is set up, the action of the bowel upon enemata is chiefly absorptive. If so, the food should either be introduced mixed with digestive substances, or else before administration should in some way or in some measure be digested, and ready for absorption into the venules and lymphatics of the intestinal walls.

The following methods are all considered good :

Leube. Three parts of meat to 1 part of pancreas, both finely minced and mixed with a sufficient quantity of warm water for clysis. Carefully remove all fat and connective tissue. The hog's pancreas is the favorite.

Rennie. To a basin of good beef-tea, add ½ lb. shredded lean raw beef ; ʒj fresh peps. porci ; ʒij dil. hydrochloric acid ; warm for four hours, stir frequently. Beaten egg or alcohol (?) may be added.

Catillon. A saturated solution at 19° C. of peptone of meat, 40 grammes ; water, 125 grammes ; laudanum, 3 to 4 drops ; bicarb. of soda, 3 centigrammes.

Dobell. Cooked, finely grated beef or mutton, 1 lb. ; pancreatic emulsion, 1 oz.; pancreatic powder, 20 grs. ; pepsine (pig's), 20 grs. Mix quickly, add half an ounce of brandy, and warm water sufficient to bring it to the consistence of treacle.

Henninger. Very lean meat, finely minced, is placed in a glass receiver ; water and hydrochloric acid are poured on, and pepsine, at the maximum of its activity, is added. The whole is left in a water-bath or stove to digest for 26 hours at 113° F.; it is then decanted into a porcelain capsule, brought to the boiling point, and whilst the liquid boils a sol. of sod. carb. is added to it, until it shows a very slight alkaline reaction. Then the boiling liquid is passed through a fine linen cloth. The liquid is reduced in bulk in a water-bath. White sugar is added before administration.

Mickle. A pint of milk, with one-fifth or one-fourth of a pint of water, is carefully heated to 140° F. Two drachms of liquor pancreaticus and 20 grains of bicarbonate of sodium in one or two ounces of water, are added. The whole, in a covered vessel, is kept near the fire at 140° F. for an hour or an hour and a half, then thoroughly boiled for two or three minutes. Thus prepared the food keeps for half a day or a day.

Dr. Mickle uses enemata of chloral hydrate in many cases of epilepsy and of epileptiform seizures. He gives thirty grains dissolved in two ounces of water, and has found it very useful.

THE NEW HYPNOTIC.—If paraldehyde should prove as reliable as the reports thus far published seem to promise, we have in it a really valuable hypnotic. The latest observer is Dr. E. Kurz, who in the *Gentrlb. f. d. cl. Med.* (18, 1884), gives the results of his experiments with the remedy on twenty-four cases. With few exceptions the effect was favorable. Usnally he administered the drug in the dose of three, sometimes four grams (gr. 1. to gr. lxv.) and in watery solution. But in this manner taken the remedy has a very disagreeable taste, and Dr. Sutter, of Illenau, recommends rum as a medium. Paraldehyde is incorporated in sugar, so that in the form of troches, one of these contains sixteen grains. Three or four of them, according to Sutter, are then dissolved in rum and a few drops of essence of lemon added. Thus prepared, the disagreeable taste is utterly concealed, and the patients do not object to take it. Its administration in *refracta dosi* is not so reliable as the effect of a single large dose. In most of K's twenty-four cases

insomnia had been complained of for a long time, and had not yielded notwithstanding the use of narcotics.

We will mention some of the diseases in which it was employed by K. for sleeplessness:

1. Phthisis, after repeated administration of paraldehyde, prompt effect.

2. Insomnia, with great restlessness after several days of railroad travel: perfectly quiet sleep restored after first dose.

3. Large ulcerated carcinoma of the mamma: after the pains had been subdued by hypodermic injections of morphia, sleep was induced by paraldehyde. Morphia and cannabis indica had not been effectnal, and choral had caused only excitement.

4. Insomnia, after violent psychical excitement: chloral had here also caused sleep, but been followed by severe headache; effect of paraldehyde instan taneous.

5. Mitral insufficiency with severe dyspnœa: neither morphia, cannabis, nor chloral caused sleep; paraldehyde did so, but partially.

6. Insomnia after typhus: morphia produced excitement; cannabis was useless; paraldehyde acted promptly.

7. Acute melancholy: prompt effect.

8. Insomnia in childhood: paraldehyde caused a quiet slumber.

9. Intra-orbital neuralgia: paraldehyde induced sleep but the effect of cannabis was still better.

The same was noticed in a tenth case, where chronic otitis had produced the sleeplessness.

Of the twenty-four cases but four evinced no or but partial hypnotic effects from the remedy. The opposite effect, excitation, as often observed from morphia and cannabis, was not seen in any case in which paraldehyde had been employed. Sleep generally set in within thirty minutes, and lasted from five to seven hours. Even in the few cases in which no hypnotic effect ensued, the patients admitted having felt much quieter after the paraldehyde; pulse became slower and arterial tension lessened, if previously increased; disagreeable effects were never noticed.—*Med. and Surg. Reporter.*

Hazeline in Menorrhagia. — According to Mr. Henry M. Chute, menorrhagia is a very frequent ailment of women in Cape Colony. He has found a valuable remedy for it, he says, in the extract of American witch hazel (*Hamamelis virginica*) or hazeline, in doses of half a teaspoonful, in sugared water, twice or three times a day. Mr. Chute states that it acts so quickly that it is not necessary to anticipate the flow, but when menstruation, after it has lasted the ordinary time, is not closing naturally, hazeline given as above will effectually restrain it, and after hæmorrhage has ceased there is no advantage in continuing it. While thus taken, some patients have mentioned that they have a pleasant sense of exhilaration, of being strung up, and have lost that wearying sense of languor felt at these times. Another good result hazeline produces is that, when there is dysmenorrhœa, it in a very quick and marked way relieves the pain. Mr. Chute mentions the case of a young lady who suffered severely—so much as to necessitate her keeping in bed, and who was once so bad as to require a hypodermic injection of morphia. Since she has taken hazeline, menstruation has been painless and not excessive as formerly.—(*South African Medical Journal*, Feb. 15, 1884.)

Pilocarpine for Deafness.—For all recent cases of deafness due to labyrinthine disturbances, whatever the primary cause may have been, Politzer tries the subcutaneous injection of a two per cent. solution of muriate of pilocarpine. He injects four drops at first, and gradually increases the dose to ten drops daily. He gets fairly good results in about one-half of the cases. I have seen three cases of persons totally deaf, who, after being treated in this way, could hear and understand loud speech spoken at the distance of a few inches from the ear; and Politzer has had one case of perfect recovery of the hearing after it had been absent for three years, and several other very satisfactory results following the use of this drug. He is about to publish the results of his experiments with the history of some of the cases. It is not known how pilocarpine acts in these cases, but the benefit derived from its use is certainly great in some of them.—*Boston Med. and Surg. Journal.*

New Treatment of Lupus.—Dr. Vidal (*Jour. de Méd. de Paris*) proposes a new method, viz., that of ether injection, to cause suppuration. He uses the common hypodermic syringe (Pravaz's), and injects from 5 to 20 drops for each injection, according to size of lupus. The injections are continued until pus formation is indicated by the fluctuation. The abscesses are then opened and the pus discharged, after which it is claimed healing takes place and the lupus disappears.

Neuralgic Dysmenorrhœa.—Professor Parvin (*Coll. and Clin. Record*) recommends the following for neuralgic dysmenorrhœa:

℞—Tinct. opii,
Tinct. valerianæ,
Spirit ætheris comp.,
Tinct. castorei, *aa* f. ʒ ij.—M.
Sig.—A teaspoonful every hour.

Chronic Bronchitis with Asthmatic Paroxysms.—Prof. Bartholow recommends Potasii iodidi, grs. xx., Liq. potasii arsenitis, gtt. ij.—Mix. Take every four hours during the paroxysm, and in the intervals between the attacks, ammonii iodidi, grs. v–x.—*Med. Bulletin.*

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science Criticism and News.

☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, OCTOBER, 1884.

The LANCET *has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

OVER-EATING AND UNDER-EATING.

We cannot imagine a closer connection between any two things than that which exists between life and nutrition. The continuance of life is dependent on the continued supply of nutrition. Even the quality or kind of life, speaking of life in an unrestricted sense, is largely influenced and moulded by the quantity and quality of nutrition supplied. Consequently we notice variations in the form and life of the plant, or the individual, according as nutrition has been normal, insufficient, or in excess. Every living thing calls for its own peculiar and natural supply, and flourishes best when a normal standard is regularly maintained. Insufficiency and superfluity of food are both usually followed by marked departure from the normal life standard. No one need be told that insufficient alimentation, in both kingdoms, is followed by a train of consequences very much similar—that the plant, or the individual, soon shows loss of health and vigor, gradually diminishes in size, and if the process of decay is permitted to proceed, finally dies. Owing to the more complex nature of the organs of assimilation in animals, and other causes needless to mention, the results of excessive alimentation are not so uniform in their operations as those of insufficient alimentation, as applied to the two kingdoms. There may be, and doubtless there are exceptions, still the rule is, even in the vegetable kingdom, that excessive alimentation is an evil to be avoided. The over-nourished wheat-stalk grows coarse and rank, but the grain is either wanting or is poor in quality. The rule more than holds its own when we ascend to the animal kingdom. Every one must be aware that even brutes suffer harm from over-feeding. But it is not till we arrive at man, that we witness all the baneful consequences of excessive alimentation.

An honored teacher of medicine, the late Dr. Rolph, used to say to his class: But few eat too little; most eat too much. The truth of that laconic remark is known to every observant person. We all know that the largest eaters are not necessarily the largest nor strongest of the race. The very opposite is nearer the mark, notwithstanding a few notable exceptions. No homely aphorism was ever truer than this one: "He eats so much that it makes him poor to carry it." It is a fact that a large majority of the lean and sickly amongst us are immoderate eaters, while a majority of the healthy and robust are moderate, or small eaters. The reason of this is easy to find. He who eats more than nature demands, imposes a heavy strain on the organs involved in the process of digestion and elimination. The stomach has a more or less definite digestive capacity, which if unduly overtaxed results in imperfect digestion, impure blood, disordered function, and gradual decay. Just as certain as we exceed the natural bounds set by nature, and overtax our stomachs to please our palates, so surely do we begin to sow the seeds of disease. True, the stomach is elastic, and marvellously accommodating, and bravely resists the assaults imprudently made on its inherent rights; but like the stone, under continued dropping, it gradually wears out.

While no reasonable person will take exception to these remarks, it is open to question, whether medical men generally are so impressed with the importance of the truth they embody as its importance merits. We hear a great deal said about "abundance of nourishing food," but very little about over-abundance. If the patient be reduced in flesh, it is too readily assumed that what he most needs is plenty of beef and other good things, while the truth may be that he has been by far too well supplied all along. Let any medical man keep a record of those chronically affected who apply to him for relief, and he will soon find that the vast majority of them have good appetites—too good in fact, and eat "abundance of nutritious food." He will find that the vast majority of this class of pa-

tients are suffering from troubles of the digestive organs, not secondarily but primarily. They are living witnesses of the literal truth of the saying, before quoted, "he eats so much that it makes him poor to carry it." For the physician to recommend a continuance of an over-generous diet under these circumstances, is to aggravate the evil. Even in the case of the under-fed it may be improper to do so, for in a weakened condition of the system it is easy to overtax the organs of digestion and so defeat all attempts at striking at the root of the malady. That physician who best excels in gauging the wants of the system and its power of assimilation, will be most successful in the cure of disease.

We do not contend that there are no under-fed or starved people in the world, or no ailment traceable to this cause. Unhappily there is too much of both. Still, outside the great centres of population, the number of the debilitated and diseased from lack of food is small, in this country. Happily for our people they have a goodly heritage, where food is both abundant and cheap, and easily obtainable by all who are able to work for it. This great and inestimable blessing is not unmixed with evil. A well laden table is sure to lead to over-indulgence, and hence we find in this country, and amongst our neighbors, more dyspeptics than can be found in all the world besides. Let over-indulgence be discontinued and the saving thus effected given to the poor, and two classes shall speedily and simultaneously disappear—the dyspeptic and the hungry.

THE CANADA MEDICAL ASSOCIATION.

The seventeenth annual meeting of the Canada Medical Association was held in Montreal on the 25th, 26th and 27th of August, and was largely attended. To say that this was by far the most successful meeting in the history of the Association is but to express the simple truth. A number of the members of the British Association for the Advancement of Science not only honored the meeting with their presence, but also took an active part in the proceedings, and gave increased interest and zest to the discussions. The papers were upon the whole very good, and were in most instances fully discussed. The event of the meeting was of course the address on "Abdominal Surgery," by Mr. Lawson Tait, of Birmingham, which will be found in another column. He was accorded a very enthusiastic reception, and the address was received with marked attention. He is a man of fine presence, speaks with a slightly Scotch accent, has a good style of delivery, and speaks with the confidence of a man who knows his subject thoroughly. The discussion which followed was also very interesting and instructive. Among those from abroad who took an active part in the proceedings may be mentioned, Drs. Protheroe Smith and his son Heywood Smith and Dr. Harley, of London; Dr. Struthers, of Aberdeen; Dr. McMillan, of Hull; Drs. McGrath and Brodie, of Detroit; Dr. Brush, of Utica; Dr. Elsberg, of New York, and others.

The Association, as in former years, was divided into two sections—Medicine and Surgery. Dr. Thorburn, of Toronto, was appointed chairman of the former, and Dr. Roddick, of Montreal, chairman of the latter. The sections met in the afternoons and evenings, and the forenoons were devoted to the general work of the Association.

The President's address consisted of a brief review of the founding of the Association and the general progress of medical science and medical education in Canada. He took occasion to praise our one-portal system of licensing in Ontario and expressed the hope that the sister Province of Quebec might soon follow in our wake, and that ere long we might have one portal for the entire Dominion. An epitome of his address will be found among the proceedings.

The profession of Montreal, so noted for their hospitality to strangers, far exceeded any previous effort in this direction, and the occasion will long be remembered by those who participated. The banquet at the Windsor was a most magnificent spread, the large dining hall being filled with guests. About two hundred sat down to dinner, among whom were a goodly number of the members of the British Science Association, both medical and lay. Dr. Hingston presided and acquitted himself in his usual happy manner, and was ably supported by Drs. Grant, F. W. Campbell, T. Rodger and Roddick in the vice-chairs. The after-dinner speeches were very good and a pleasant evening was spent by all who had the good fortune to be present.

Dr. Osler was unanimously chosen President for the ensuing year, and Winnipeg selected as the next place of meeting, on the third Tuesday in August, 1885.

MEDICAL MEN'S FEES.

A test case was recently tried in Belleville, Ont., to determine whether or not a patient is liable for the fees of a medical man who is called by a friend or relative. In this case the brother of the patient summoned the consulting physician, who assisted in the amputation of a finger. The patient refused to pay the consulting physician on the ground that he had not engaged him, and told him to look to the attending physician for his fee. The Judge who tried the case ordered a non-suit, holding that the patient was responsible only to the physician he engaged. We are a little surprised at the ruling of the Judge in this case, as we had always entertained the idea that if the patient accepted the services of a physician, he was bound to pay him. It is a well-recognized principle among the medical profession that when a medical man is called in consultation the patient is responsible for the payment of the fee. In view of the Judge's ruling in this case the question might well be asked, Who is to be responsible for the fees where the patient is unconscious and incapable of engaging anyone? One not versed in the intricacies of the law would naturally suppose that a patient's brother could safely be considered an authorized agent to engage the services of a medical man, but such it seems is not the case. And if a patient is not responsible for the fees of a medical man who has been engaged by his brother, what are the chances of having a legal claim to remuneration for services rendered when the party who calls the physician is only a neighbor, a friend, or, in case of emergency, possibly a stranger?

MALPRACTICE SUIT.—A suit to recover $2000 damages for alleged malpractice was recently tried in Walkerton, Ont. The plaintiff, Mr. Robertson, received a fracture in the lower third of the thigh in November last, and the defendant, Dr. H. A. Bonnar, of Chesley, Ont., was called to treat him, which he did in the usual way by means of a weight and pully, together with the use of coaptation splints. The treatment was continued eight weeks and upon examination there was found to be ¾ of an inch shortening, besides a considerable degree of angular displacement at the seat of fracture. There was also some stiffness of the knee joint. The plaintiff alleged that the defendant had not treated the fracture properly, and also that he allowed him to use his limb before union had taken place. The plaintiff's views were supported only by the evidence of Dr. Cooke of Chesley who was called in to treat the patient after Dr. Bonnar had discontinued his attendance. For the defence it was shown by Drs. Fulton and White of Toronto and several other medical gentlemen in the locality, that Dr. Bonnar had treated the plaintiff skillfully and carefully, and was not in any way to blame for the result. The shortening was not more than the average in fracture of the thigh, and the deformity did not interfere with the utility of the limb. At the close of the plaintiff's case the Judge said there was no evidence to go to the jury as to the allegation that the method adopted by the doctor was an improper one, as it had been proved to be a method sanctioned by the highest authority. He would have to leave the other portion of the case to the jury, as to whether the doctor had carefully attended his patient and to say whether the result had been what might naturally be expected if the plaintiff had been properly treated, even assuming the method adopted to be a proper authorized one. The jury failing to agree were discharged. We congratulate Dr. Bonnar on the result of the trial.

ONTARIO MEDICAL COUNCIL ELECTIONS. — The following gentlemen have been recently nominated as candidates for the Erie and Niagara Division in the Medical Council, viz.: Dr. Philip, of Brantford, and Dr. Thos. T. Harrison, of Selkirk. With one or two exceptions the old members will be candidates for re-election, and as they were for the most part faithful to their trust, we hope to see them returned. We give the following extract from the by-law for conducting the elections which take place on the 4th Tuesday in May, 1885:

"Any member presenting himself for election as the Representative to the Medical Council for a Territorial Division, must receive the nomination of at least ten (10) registered practitioners resident in such division, and such nomination paper must be in the hands of the Returning Officer for the division not later than 2 o'clock on the afternoon of the first Tuesday in May, 1885. The Registrar shall send to every registered member of the College, entitled to receive the same, a voting paper,

(in accordance with residence given on the register), by the second Tuesday in May, 1885. Any member of the College not having received a voting paper, when more than one candidate has been properly nominated for his division, will send by post to the Registrar his name and address.'"

Gun-shot Wounds of the Intestines.—Dr. Parkes, of Rush Medical College, Chicago, has been experimenting on gun-shot wounds of the intestine in dogs, and gives the result in a paper read before the Am. Med. Association. The experiments show in the most unmistakeable manner the utility and value of abdominal section, and stitching of the bowel. He recommends a modification of the *Lembert* suture, as the most satisfactory, but states in conclusion that it makes no difference what kind of suture is used, so long as the principle of securing the application of two broad surfaces of peritoneum in contact with each other is carried out. He used both silk and catgut. The sutures were introduced about the third of an inch from the divided edges, made to include the peritoneal and muscular coats *only*, and brought out just free of the edge on one side, and similarly inserted on the other. The lacerated part was first excised and bleeding arrested.

Ligature oe the Common Carotid.—Dr. W. Honeywell, of New Glasgow, P.E.I., with the assistance of Drs. Toombs and Gallant, of Cardigan, successfully ligated the common carotid, below the cricoid cartilage, a short time ago. The patient, a sailor, fell down stairs in a vessel on a piece of earthenware, which penetrated his neck below the under jaw, making a ragged wound about two inches deep and wounding the external carotid. The usual incision was made along the anterior border of the sterno-mastoid, and the vessel tied with a prepared violin string (this was kept in oil of juniper for six weeks, then put in alcohol). The wound was washed out with a solution of corrosive sublimate (1 to 2000) then covered with iodoform gauze. It healed by first intention, and the patient recovered without a bad symptom, except a little vertigo.

Pontiac County Association, Que. — The members of the medical profession of this county, met at Portage du Fort on the 12th ult, for the purpose of organizing, revising the tariff and discussing matters appertaining to the fraternity. There was a good attendance present. Dr. Purvis was elected *President*, Dr. Lyon *Vice-President*, and Dr. Knox, *Sec.-Treas.*

A tarriff of fees was considered and adopted. The annual fee to defray the expenses of the association was fixed at $1. The association will meet three times in the year, on the second Tuesday of May, January and September. As there are a few medical men practising in the county without licenses it was unanimously agreed that proceedings be taken against them forthwith. The next meeting of the association will be held at Shawville.

Colorado Beetles in the Stomach. — Dr. Harrison, of Keene, Ont., sends us the following: On July 9th, a child two years old was brought to his surgery very ill. The symptoms were indicative of intestinal and alimentary irritation, with tendency to stupor. He was doubtful about the cause, but thought it might be due to worms or something the child had eaten. He gave some powders of santonine, aloine, etc. Two days after the parents were amazed and alarmed at seeing the child pass a large quantity of Colorada beetles in the pupa state. The child continued to improve steadily as soon as rid of the offenders. Strange to say they did not appear to be the least inconvenienced by their sojourn in the child's stomach.

Appointments.—The following gentlemen have been appointed examiners under the Civil Service Acts, 1882 and 1883:—Drs. M. Sullivan, Kingston; C. J. Samson, Quebec; P. Conroy, Charlottetown, P. E. I.; J. B. Matthews, Victoria, B.C.; W. Canniff, Toronto; and Dr. Codd, Winnipeg.

Dr. C. W. Belton, has been appointed medical superintendent of the London General Hospital, *vice* Dr. Wilkinson resigned.

Dr. Bruce, of Woodstock, N. B., has been appointed on the staff of the St. John Public Hospital, *vice* Dr. Coleman, who is about leaving the city.

Ergot in Chorea. — The value of ergot in many affections of the cerebro-spinal system is well known. On the assumption that the smaller vessels of the brain, as Dr. Dickinson maintains, are in a state of dilatation, Dr. Forrest (*London Lancet*) has been experimenting with this remedy in

chorea. He began by giving the fluid extract in five minim doses, and the results have been on the whole satisfactory.

TREATMENT OF GONORRHŒA. — The following suggested by a retired army surgeon is going the rounds of the press as a cure for gonorrhœa—

℞ Zinci sulph.
Ext. Belladonnæ aa grs. xx.
Mucilag acaciæ ʒi
Aquæ ad. ʒviii.—M.

Sig.—A teaspoonful to be injected frequently. An ointment of opium, and belladonna also to be smeared along the perineum and crus penis at night.

HALDIMAND COUNTY MEDICAL SOCIETY.—At a meeting of the above-named society held in Caledonia on the 19th ult., the following officers were re-elected, viz.: Dr. Dee, *President;* Dr. Davis, *Treasurer;* and Dr. Forbes, *Secretary.* On motion of Dr. Harris, seconded by Dr. Baxter, Dr. Harrison, of Selkirk, was nominated for election to the Ontario Medical Council (1885) for the Erie and Niagara Division.

ARREST OF TUBAL PREGNANCY.—Dr. Mundé, of New York, reports in the *Medical Record* a successful case of arrest of tubal pregnancy by galvanism. One electrode was placed in the rectum and the other over the mass, and the strength of the current gradually increased to 24 cells. The patient though much prostrated at the time made a good recovery.

PROFESSIONAL EXAMINATION. — The following gentlemen have passed the supplemental examination for M.D. C.M. in McGill College. D. A. Cameron, Strathroy, Ont.; J. T. Mackenzie, Belleville, Ont.; J. A. McArthur, London, Ont.; and J. C. Sharpe, Sussex, N.B.

Dr. Lawson Tait, contrary to his original intention, has been doing some operative surgery on this side the water. In Hamilton, he opened the abdomen for supposed gall stones, but found carcinoma instead. In Albany and New York he performed three operations for removal of the ovaries and one hysterectomy.

PERSONAL.— Dr. Osler of Montreal was entertained by the Toronto Medical Society on the 25th ult. prior to his departure for Philadelphia to enter upon his duties as Prof. of Clinical Medicine in the University of Pennsylvania.

ADMINISTRATION OF IRON—To prevent the disturbance of the stomach, occasioned by tincture of iron, it should be combined with muriate of ammonia in the proportion of one part to two of the tincture. This also renders it more palatable.

PRURITUS.—The latest remedy for this troublesome affection, when seated in the anus or vulva is balsam of Peru. The *British Medical Journal* alludes to it as a new triumph in medicine.

The *Lancet*, September 20th, contains a notice of the death of Dr. Radcliffe, whose name has been so long associated with public health matters in England.

The next meeting of the International Medical Congress, as was anticipated in our last issue, will be held in Washington in 1887.

BRITISH DIPLOMAS.—Drs. T. McCullough and J. E. Brown (Trinity) have successfully passed the required examination for the L.R.C.P. Edin.

THE death of Prof. Cohnheim, of Leipsic, is announced in our foreign exchanges.

Books and Pamphlets.

A MANUAL OF DISEASE OF THE THROAT AND NOSE, including the Pharynx, Larynx, Trachea, Œsophagus, Nose and Naso-pharynx, by Morell McKenzie, M.D., Lond. New York: Wm. Wood & Co. Toronto: Hart & Co.

This is the second volume of the above-named work, embracing the "Diseases of the Œsophagus, Nose and Naso-pharynx," and constituting the August number of Wood's Library of Standard Authors. It is nearly twelve years, the author states, since the work was commenced, and during that time there is scarcely a page that has not been written and re-written many times. He has been at great pains to make the work a faithful exponent of the science and practice in this important department of medicine. The work bears evidence of the care and attention which has been bestowed upon its

preparation. The reputation of the author as a specialist in this field is too well known to require any notice at our hands.

A Practical Treatise on Diseases in Children, by Eustace Smith, M.D., F.R.C.P. Lond., Physician to the East London Children's Hospital. New York: Wm. Wood & Co. Toronto: Williamson & Co.

The opportunities of the author as well as his reputation as a practitioner, entitle his work to the favorable consideration of the profession on both sides of the Atlantic. The author discusses the whole subject of disease in early life, and deals with it purely from a clinical standpoint. Each subject has been treated very fully, and great care has been bestowed on the sections relating to diagnosis and treatment. Due prominence has also been given to the important subjects of diet and hygiene. Many interesting cases from the author's case-books, by way of illustration, have been introduced into the text. It is the most complete work of the kind in the English language, embracing in 12 parts the following: Acute infectious, non-infectious, diathetic, glandular, nervous, respiratory, circulatory, mouth and throat, digestive, hepatic, genito-urinary, and skin diseases. We commend the work to the Canadian profession.

The Popular Science Monthly for September, 1884. New York: D. Appleton & Co. Fifty cents a number, $5 a year.

The frontispiece of the September "Popular Science Monthly" is a fine portrait of Professor J. P. Lesley, chief geologist for Pennsylvania, and President of the American Association for the Advancement of Science. Prof. J. P. Cooke's article (Harvard University) on "Scientific Culture: its Spirit, its Aim, and its Methods," is an able exposition of this subject. In "National Health and Work," Sir James Paget strikingly presents an additional reason for sanitary activity in the loss which results to the nation from the sickness and early death of its workers. Among other articles may be mentioned: "Sorghum as a Source of Sugar," "Hygiene for Smokers," "Sun Kinks," "The Problem of Population," "Protection against Lightning," etc. The editor writes on the meetings of the British and American Associations, and discusses a recent article by Bonamy Price, under the heading, "The College Feitch once more."

A Manual of Obstetrics, by Ed. L. Partridge, M.D., Prof. of Obstetrics New York Post-graduate Medical School, etc., with sixty illustrations New York: Wm. Wood & Co. Toronto: Williamson & Co.

This is a very convenient pocket manual, and as such will be found useful by young men commencing practice, for reference in perplexing cases at the bed-side. The author has given a very concise and correct outline of this important subject, and medical students will find it valuable in making readily available their store of knowledge in a professional examination.

Manual of Auscultation, Percussion and Urinalysis, Illustrated. By C. Henri Leonard, M. A., M. D. Detroit: Illustrated Medical Journal Co.

This unpretentious little work contains a complete epitome of the physical signs of the heart, lungs, liver, kidney and spleen in health and disease. The matter is so condensed that a great deal of information is compressed into a very small compass. The illustrations are fairly good and the text clear and explicit. Dr. Leonard is quite an adept at this kind of work, having already published several of like nature, such as "Vest-Pocket Anatomist," "Reference and Dose Book," "Bandaging," "Hair and its Diseases," etc.

The Care and Feeding of Infants, by Doliber, Goodale & Co., Boston, Mass.

This pamphlet, which deals with the essentials of feeding infants, invalids, etc., will be sent free to any address on application.

Visions of Fancy. A poetical work, by N. M. Baskett, M.D., of Moberly, Mo. St. Louis, Mo: Commercial Printing Co.

Births, Marriages and Deaths.

At Moorefield, Ont., on the 14th ult., Dr. Henry Mandesley, aged 54 years.

At Arichat, N. S., on the 13th ult., Henry C. Fixott, M.D., M.R.C.S., Eng., aged 64 years.

On the 25th ult., Dr. Edward Morton of Queensville, Ont.

On the 11th ult., Dr. G. A. Kent, of Wallace, N.S.

THE CANADA LANCET.

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Original Communications.

THE EFFECTS OF TOBACCO.*

BY W. F. COLEMAN, M.D., M.R.C.S., ENG., ST. JOHN, N.B.

Mr. President and Gentlemen,—At our last meeting the President referred to a case of faint cardiac murmur in a very healthy man who smoked a good deal, and questioned as to the possible connection between the tobacco and the murmur. This suggested to me "The Effects of Tobacco" as a subject for this evening's consideration. In regard to one field of observation, I have a very decided view, and am anxious to get the benefit of your experience in a more general field. The universality of puffing and chewing the fragrant weed, and the potency of tobacco as a poison, make the question of the effect of its habitual or remedial use an important one. Tobacco belongs to the family solanaceæ, which embraces such members as hyosciamus, belladonna, stramonium, and curiously enough, the potato. Its important active principles are a colorless liquid alkaloid, called nicotine, a poison "which almost equals hydrocyanic acid in activity" and a camphoraceous volatile oil, nicotianin. By burning tobacco, an empyreumatic oil is produced from the decomposition of some of its constituents, which as found in the pipe of the smoker, is an active poison, and appears to be (Christison says) nicotine attached to a true volatile oil. The proportion of nicotine varies in different sorts of tobacco, and the quantity usually present is by various chemists estimated from 2% to one part in ten thousand. Two or three drops of nicotine or 3ss. of tobacco may cause death. The death of two brothers is reported from the continuous smoking of 17-18 pipes. Pereira gives a case in which twelve drops of an infusion of tobacco given as an enema caused death.

*Read before the New Brunswick Medical Society.

Von Boeck on vegetable poisons, says, "It is from smoking tobacco that nicotine poisoning chiefly arises, the smoke itself containing the nicotine. A great deal of it accumulates on the lower part of the pipes, and the remains of cigars are much more impregnated with it than the parts fresh smoked. Large poisonous doses of tobacco are said to produce syncope, small pulse and labored respiration. In most cases convulsions supervene. The pupils are at first dilated, then contracted. There is prolonged collapse and finally death."

Erb, of Heidelburg, says: Various authors adduce excessive tobacco smoking among the causes of tabes dorsalis. I would here say, in anticipation, if we can prove, as we think possible, that tobacco smoking often produces inflammation and atrophy of the optic nerve, is it not more than probable that it can and does produce myelitis, followed by atrophy of the cord, the admitted pathology of tabes dorsalis. Beau describes eight cases of angina pectoris, in which the attacks ceased when smoking was stopped, and returned when the patients began to smoke. Headland places tobacco under the class neurotics, order inebriants. The observations of Claude Bernard that nicotine at first produces contraction of the arteries, and later on the vessels become distended, agree with the results of the physiological researches of Uspensky, who concludes that nicotine first stimulates then paralyses the vaso-motor centres.

From personal experience and the literature at my command, I know of no more constant detrimental effect of the abuse of tobacco than impairment of sight, ranging from slight defect to total blindness. The abuse of tobacco is so frequently associated with drinking to excess, that it is questioned by some whether tobacco alone ever produces impaired sight, or whether the tobacco or alcohol is the chief factor. My own opinion is, that tobacco alone is quite able to produce imperfect sight. Dr. Webster, of New York, in an able paper reporting twenty cases of amblyopia from the abuse of alcohol and tobacco, remarks, "That the abuse of alcohol alone, or of alcohol and tobacco combined, may produce impairment of vision, no physician acquainted with the subject will, I think, venture to deny. Some, however, doubt that tobacco alone ever causes impairment

of vision, and indeed it is difficult to demonstrate that it ever does." Now, in looking over Dr. Webster's cases, I find not one in which the patient who used alcohol did not *smoke* to excess. On the other hand two who smoked to excess used so little alcohol that I think even Dr. Webster would not claim it had any share in the effect upon sight, proving, so far as Dr. Webster's cases are concerned, that tobacco alone may impair sight, and that in no case was alcohol the only or even the chief factor in the causation of the amblyopia.

E. g. Case 7, C. McK—, æt. 49. Has smoked 10-15 strong cigars daily for ten years ; *occasionally* drinks a glass or two of gin. Vision = $\frac{1}{18}$ each eye. Incipient atrophy of optic nerves.

Case 12, æt. 60. Sight failing over a year. Has smoked a strong pipe most of his waking hours for more than forty years. Has *rarely* tasted liquor. Vision equals $\frac{1}{10}$ each eye. Brick dust atrophy of both optic nerves. Ordered to stop tobacco, and return in a week. *Then* vision in right eye *doubled*, in left eye all but doubled.

McKenzie, one of the worthy fathers of ophthalmology, originally pointed out the effects of tobacco. In 1840 he wrote, " I have already had occasion repeatedly to hint my suspicion that one of the narcotico-acrids, which custom has foolishly introduced into common use, namely tobacco, is a frequent cause of amaurosis." In that pre-ophthalmoscopic day, amaurosis meant obscurity of vision, depending upon a supposed morbid condition of the retina or optic nerve (McKenzie). In the present day, the terms amaurosis and amblyopia give rise to great confusion, from their various application. It would perhaps be best to restrict the term amblyopia to all cases of impaired sight, and amaurosis to cases of absolute blindness, without ophthalmoscopic symptoms. More recently, Wordsworth, Critchett, Hutchinson, &c., have given great attention to the effects of tobacco upon the eye, and believe it gives rise to impaired sight and blindness, with or without ophthalmoscopic signs. Hutchinson, who is probably the best authority on tobacco amaurosis, wrote in 1867 as follows: " The first stage, one which is very transitory, and perhaps often altogether omitted, is one of congestion, during which the optic disc looks too red. Then follows pallor of the outer parts of the nerve disc. During these stages the patient complains of dimness of vision merely. In a later stage the whole disc has become pale, even to blue milk whiteness, and later still there is advanced atrophy. The stages generally occupy from four months to a year. In many cases the patient becomes at length absolutely blind, but in others the disease having advanced to a certain point, is arrested. There is from first to last no evidence of any disease of any structure in the eyeball, excepting the optic nerve. Almost always both eyes are affected, and progress *pari passu*. Sleepiness, a little giddiness, and a little headache, are usually the only constitutional symptoms which attend it." Three-fourths of his cases recovered. In a personal interview with Mr. Hutchinson at Moorfield, in 1875, he remarked he had come to think the effect of alcohol antagonistic to tobacco, as a cause of amblyopia, unless the alcohol is taken in such excess as to produce degenerative or undermining effects on the constitution. He had seen amblyopia more frequently and more advanced in smokers who abstained from alcohol, than in those who took it. Dr. Berry also holds a similar opinion. He cites two cases of tobacco amblyopia ; one a man of seventy, who had been a teetotaller for forty years, and the other a boy of 19, who did not drink. Berry, in common with many others, has remarked the symptoms often gradually disappear on the cessation of smoking, without any other treatment, and frequently without the supply of alcohol being diminished.

Since Hutchinson's description of tobacco amblyopia in '67, he, in common with many others, has examined more systematically the field of vision and color vision, and has found that the diminution in sight is confined to central or direct vision, while usually, eccentric vision remained relatively good, and they have found that color-blindness exists over a portion or the entire extent of the visual field. The color-blindness is for red or green, the red appearing blue, and the green appearing white, gray or yellow. The color-blindness in slight cases of amblyopia requires very careful examination to determine, as it is confined to the central part of the field, particularly within an area stretching from the optic nerve to the macula.

In 37 cases of atrophy of the optic nerve, Hutchinson attributed 30 to the effects of tobacco, and in 36 cases of optic nerve atrophy, Lebr found color-blindness an almost constant symptom, the

perception of color remaining intact in only three. Berry says he has looked out for the symptoms of tobacco amblyopia in women for the last five or six years, and has only met with them in three cases. These three women smoked to excess, but did not drink. Forster cites 20 cases, in a paper on the injurious action of tobacco on vision, each one of the patients being a strong smoker, and only able to see very large type. In 11 of these cases marked improvement was observed when the use of tobacco was given up. I will not detain you by quoting the language in the text-books on diseases of the eye at my command, by authors who express their full belief in tobacco amblyopia and amaurosis, simply stating they are English, Scotch, American, German and French, and among the best authorities. The authors are, McKenzie, Wolfe, Gowers, Wells, Nettleship, Noyes, Williamson, Stellwag, Schweigger, Grunfeld, Mittendorf, Mayer, and De Wecker. The only two authors I have who dissent from the general view are Carter and Lawson, English. Carter quotes a letter from Dr. Dickson, of Constantinople, to the effect that the consumption of tobacco in that city averages 3 lbs. weight per head per month, but that amaurosis is a rare affection there. He quotes also Dr. Hubsch, oculist in Constantinople, who writes, "I have never attributed amaurosis to the abuse of tobacco." Carter adds, "I have obtained the same kind of negative evidence from Egypt and India, and in the face of it I do not attach much importance to the fact that several patients who have suffered from nerve atrophy, have been great smokers. If a patient who consults me on account of nerve atrophy is a smoker, I always advise him to lay aside tobacco. This would be dictated by the duty of leaving nothing undone, and would not represent any personal belief in the necessity of the prohibition." I cannot comprehend why Mr. Carter thinks it his duty to give advice in which he does not believe, unless he thinks the belief of others a stronger reason for his duty than his personal belief, in which case he must hold his own opinion very feebly. Mr. Lawson, one of the surgeons of Moorfield Eye Hospital, thus writes: "I do not remember ever having seen a case in which the loss of sight could be fairly attributed to tobacco only. There was also in addition to the immoderate smoking some other excess, such as intemperance, or undue mental strain with loss of rest."

In looking over my notes of 1824 eye patients who have consulted me since 1877, I find 46 who had partial to total loss of sight accompanied by conditions of the eye similar to those noticed in tobacco amblyopia, viz., either no ophthalmoscopic or otherwise detectable change of the eye, or else hyperæmia, pallor, or atrophy of the optic papilla. These 46 cases may be thus classified: male 33, females 13 (46). Cases referred to smoking alone, 13; tobacco and alcohol, 9; alcohol alone, 0; other causes, 24. Tobacco and alcohol, males 9, females, 0; tobacco, males 13, females 0; other causes, males 10, females 14. Cases in which there was hyperæmia, pallor, or atrophy of the disc: tobacco, 12 male; alcohol and tobacco, 9 male; other causes, 7 male, 11 female. In regard to these figures I would remark that although no case of pure alcoholic amblyopia appears, it is because every one of the drinkers who consulted me was an excessive smoker, a rule, perhaps, with few exceptions, yet I believe amblyopia potatorum is an entity, as is very generally held in Paris. I must admit not having questioned females as to smoking and drinking, as they are so free from such male virtues. Again, in all the cases but one of tobacco or tobacco and alcohol, I noticed changes in the optic disc, as the patients did not consult me in an early stage, when ophthalmoscopic changes are not noticeable. I will briefly refer to four patients who did not take alcohol and had tobacco amblyopia:

J. T., æt. 44, consulted me in Feb. 83, complaining that his sight had been defective for eight months, and he was unable to see more than half a word at a time with either eye, seeing the half on nasal side. Vision is one-half in left and one-third in right eye; outer half of each optic papilla pale. Patient has smoked six pipefuls daily for 15 years past. Advised to take strychnia and stop tobacco. Patient returned in two months, said he had followed advice and sight was all right.

H. O., æt. 21, Dec. 28, '83, said both eyes had gradually failed during the past 15 months, and now he can barely distinguish light. There is advanced atrophy of both optic discs. No symptoms of brain or spinal disease, no history of syphilis, health good. Has for four years past smoked 6-7 pipefuls daily, and chewed one-fifth lb. of tobacco weekly. *Treatment*—Strychnia, hypodermically, m iv. ter die. (grs. iv., ad ℥ i.

solution) and increase mj. daily; stop tobacco. Strychnia spasm was not felt till the dose reached m xxv, equal gr. one-fifth, and then only occasionally felt. Vision remained the same after one month's treatment. Feb. 4, '84.—℞ Strychnia, gr. $\frac{1}{75}$ ter die. by stomach, and gradually increase the dose. Feb. 8th—Apply galvanic electricity to nape of neck and closed lids, three minutes daily to each eye. Feb. 27th—Taking strychnia gr. $\frac{1}{5}$ ter die, by stomach, and feels spasm only occasionally. Vision, each eye increased to $\frac{1}{70}$. April 7th, '84.—Discharged with vision $\frac{1}{70}$, and able to see his way about well. Patient only diminished the amount of his smoking.

Nov. 25, '80—J. McK, æt. 31. Sight failing three months. Vision, right or left eye, $= \frac{1}{17}$. Has smoked since 11 years of age, and for three years past 10 pipes a day. Takes a glass or two of whiskey only once in months. Both papillæ hyperæmic. *Treatment*—Stop tobacco, cup temples, take iodide of potassium. Jan. 5, '81—Patient returned; stopped tobacco and gained 12 pounds in weight. Vision has increased from $\frac{1}{17}$ to $\frac{1}{5}$. Outer half of discs now pale. Jan. 20th—White atrophic lines on discs and along vessels, perivascular atrophy; vision the same. Prescribed strychnia.

Oct. 22, '79.—W. S., æt. 21, noticed nine months ago while in school he could not see to read with right eye, and six months ago noticed the same defect in the left, but two weeks later could see to read fairly well. A week later still the eye again failed. With right eye can count fingers at 6″ on temporal side only. With left eye, vision is $\frac{1}{164}$ = $\frac{1}{4}$ = 16 (Jaeger). Fundus of eye normal, unless there is some engorgement of retinal veins. Patient is anæmic and nervous, but he considers his health pretty good. Has smoked 6-8 pipes a day, from the age of 15, until two years ago, and 3-4 pipes daily since. Diagnosis, tobacco amblyopia. Prescribed strychnia. Discharged after nine days' treatment, with vision of right eye increased 8 times, and doubled in left eye. Continue strychnia by stomach.

Finally, gentlemen, I am prepared to hear you maintain that impaired sight, the use of tobacco, and the wearing of leather boots, for instance, are coincidences, only that and nothing more. The only additional argument in favor of tobacco amblyopia I shall detain you with is, that the quality of the tobacco and the mode of smoking in Turkey differ so much from the "shag" of England, and the mode of smoking in England and America, as possibly to account for the absence of tobacco amblyopia in Constantinople. Sir Henry Thompson says the ladies of Constantinople smoke fifty cigarettes a day, merely taking a few whiffs from each, and then throwing the cigarette away, and he considers little harm ensues from such smoking. To deny that tobacco produces amblyopia, because a large number of smokers escape, is as rational as to deny that small-pox can reproduce itself, because a large number of the exposed may escape the disease, or to deny that cold or wet can produce rheumatism, because so few of the exposed suffer.

ON TRACHELORRHAPHY—WITH CASES*

BY DR. SKENE KEITH, EDINBURGH.

(Reported by Dr. H. Aubrey Husband.)

The operation for restoring a torn cervix uteri is not yet generally recognised in the southern part of this country, and some of the so-called Emmet's operations would greatly astonish the great American apostle of clipping and stitching. The few cases he had to relate brought out forcibly the necessity for following up the after history of the patients. He had heard of several cases who were no better some months after the operation, and who were supposed by the operator to have been cured, for example, he knew of a lady who a few months after the operation was no better but rather worse, as she was suffering from constant bloody discharge in addition to her other troubles. This discharge was accounted for by the presence of a wire suture in one lip and want of improvement by complete failure of union, yet it may have been put down as a cure as the patient did not see the operator after the first few weeks.

CASE I.—Mrs. G. had suffered for fifteen years from pain in both groins and from a constant aching in the region of the sacrum since the birth of her only child. The labor had been a natural one. After years of treatment she at last saw Prof. Skene, of Brooklyn, and was advised by him to have the cervix uteri repaired The cervix was torn on both sides of the os, almost to the vagina,

* Read before the Obstetrical Society of Edinburgh, July 9, 1884.

and there was some, although not very marked, rolling out of the lips. The uterus was of normal size, and was not displaced. Dr. Skene allowed me to perform the operation and assisted me on the 21st December, 1881. Sims' speculum was used to bring the cervix into view in this and the other operations. After passing a sound I fixed on each lip of the cervix a double tenaculum at the spot where the centre of the external os was to be. With Skene's hawk-bill and Emmet's scissors I pared first the left and then the right side of the cervix leaving the central part untouched for the cervical canal. There was little hemorrhage. Three sutures were required on each side and after they had been tied up I passed a sound to be quite sure that the cervical canal was patent. This precaution is not altogether unnecessary, for I have since seen a cervix on which a so-called Emmet's operation had been performed, but where the menstrual discharges after the operation escaped through a small opening at the junction of the cervix with the vagina. There was retention of urine for twenty-four hours, and this was the only trouble the patient had after the operation. The sutures were removed on the seventh day, she sat up on the tenth, and at the end of a fortnight she came to Dr. Skene's office. The union was not as good as it might have been. However, the backache was quite gone, and the pain in the loins was not so bad. I have not heard of her since.

CASE II.—A lady, age 26, was seen by my father in April, 1882. Two years before she had been delivered of a seven month child with forceps, after having been in labor with convulsions for 48 hours. Since then she has suffered from constant backache and leucorrhœa. On examination with the speculum it was seen that the left side of the cervix was torn, and that the tear extended into the mucous membrane of the vagina. The right side was intact. The cavity of the uterus was increased to four inches, and there was no displacement. In May, 1882, I operated in the same way as in the previous case, except that one side only had to be repaired, and that two of the eight silk sutures which were required were entirely in the vaginal wall. After the stitches had been tied the tear measured two and a half inches. The patient had no trouble after the operation. On the ninth day two of the sutures about the centre of the line were found to have cut their way out. Injections of hot water were given night and morning, and the other silk sutures were left in for two days more. Three weeks after the operation the cervix looked almost as though there had never been anything the matter with it. The uterus now measured two and a half inches. The backache and leucorrhœa had entirely disappeared. This lady kept perfectly well for seventeen months. She was then delivered of a child at term and since has had a slight return of the old trouble. A short time ago my father found that there was a slight tear anterior to the former one.

CASE III.—The patient, age 29, came under notice in March, 1882. She had at that time been suffering for four and a half years, since the birth of her only child, from backache and pain in the left groin. The labor had been a natural one. The backache has steadily increased, and more especially during the last twelve months. The cervix was hard, torn on the left side only. In July I operated. On account of the hardness and hypertrophy of the cervix I had to remove a thick slice of tissue before I was able to turn in the everted edges. The bleeding was rather free at first, but had quite ceased before I introduced the five sutures which were necessary to bring the parts nicely into position. The sutures were taken out on the ninth day, and on the eighteenth the patient went home. The line of union was very good, the backache was gone, and the pain in the left side was somewhat better. In December of same year the patient wrote to say that she had no pain and was cured. She kept well until six months ago, the leucorrhœa appeared accompanied with occasional pain in the side and back. Her doctor told her that she was much better for having had the operation done, so I suppose that the present illness is not due to my opening up of the cicatrix.

CASE IV.—Mrs. H., age 31, suffered from backache, pain in the groin, and leucorrhœa for ten months, since an abortion at about the fourth month. She had been a patient of Mr. Butler Smythe at the Grosvener Hospital for Women and Children, Westminster, for a number of weeks, and had improved to a certain point, but could not be made to advance further by any of the usual treatment for such cases When Mr. Smythe asked me to look at the case the cervix was torn on both sides, principally on the left, and the everted edges

were covered by exuberant granulations which bled easily. The uterine cavity measured two and a half inches, and the sound passed backwards with a slight curve. Mr. Smythe asked me to operate and I did so in April, 1883. There was no special difficulty in the operation. I was able to raw the right side with one snip of the hawk bill scissors, as the tear on that side was small and required but one suture; three were put in on the left. Patient suffered from no pain or disturbance after the operation. When she left the hospital the cervix looked beautiful. The leucorrhœa was quite stopped, the backache somewhat better, and the pain in the groin as bad as ever. Now she is perfectly well.

CASE V.—Mrs. M., age 36, has not felt well for years, and since the birth of her last child, seventeen months before I saw her, had suffered from constant backache and leucorrhœa, and frequently from facial neuralgia. On examination, the perineum was found to be partially torn, and what was left of it was lax and soft. There was a considerable rectocele, and this caused great straining at stool. The cervix was low down, large, hard, torn, and the lips were much everted, the posterior being fully twice as thick as the anterior. The uterus was slightly retroverted and the cavity measured three inches. In May, 1883, I pared and brought together the everted lips. There was some difficulty in doing this on account of the difference in the thickness. Six sutures in all were put in. At the same sitting I cured the rectocele by repairing the perineum. Five weeks after the operation the cervix could not have looked better. The patient went to the seaside, and although she came back looking very anæmic and not fully well, there had been no leucorrhœa or face-ache, and the back did not pain her as much as formerly. In December the backache began to get worse, and I found that my patient had become pregnant, and about one-third of the cicatrix in the cervix had given way. She aborted, and I again pared and brought together the everted edges, this time with wire. A week ago the patient wrote to say that she was feeling much better.

CASE VI.—Mrs. L., age 21, was well until after the birth of her second child, four years ago. After getting up she suffered from bearing-down pains, which were relieved by wearing a pessary. Six months ago she was delivered of a boy baby, with forceps, and remained in bed for five weeks. Since then she has suffered from constant backache and pain in the left groin, and she has a profuse yellow discharge. When I saw the patient last November, the uterus lay low in the pelvis. The cervix was deeply torn on both sides, and there was a great deal of rolling out of the lips. The vagina contained a large amount of glairy mucus. After two months' treatment as an out-patient, during which time the cervix decreased in size the leucorrhœa got less. I thought that the tear would not improve further as it was an irregular one and I therefore operated. On the ninth day the patient felt perfectly well and had no pain. She went home at the end of three weeks, nursed her two children with measels, and her husband, who was also ill, and felt perfectly well for three months. Since then she had profuse discharge with pain in the stomach, and I have heard from Mr. Malcolm, who has been at the Samaritan Free Hospital, that there is considerable suppuration along the lines of the cicatrix on the right side, though the deeper parts appear to be quite firm.

REMARKS.—The operation of Emmet, when properly performed, is certainly of benefit in suitable cases, but I do not believe that it ought to be a very common one, for there are few women who have had a child without having their cervix uteri more or less injured, and most of these injuries do little harm. In my notes of a year's out-patient practice in the Samaritan Free Hospital, I found that I have marked down that there was a well-marked cervical tear in forty-two cases, yet in five only did I recommend operation and two of these five were on account of induration due to excessive application of caustics. Careful application of a mixture of carbolic acid and tincture of iodine with the hot douche and support of the uterus when necessary was found quite sufficient to heal up the other cases. Even in the Women's Hospital, New York, Emmet's operation is not a very common one. In four and a half months of the winter of 1881-2 I saw it performed there 24 times, and I was present at all the operations during that time. Trachelorrhaphy is not a very easy operation, at least, in most of the necessary cases, for in those the tissues of the cervix are much harder than natural. Where it is safe to draw the cervix entirely outside the vulva there would be little difficulty, but as this cannot be done I have found

that the most easy position is to have the cervix at its natural place at the upper part of the vagina, provided always that the patient is placed well in Sims' position and that the speculum is well held. There is far more room here than at any other part of the vagina. In forty cases I have but once seen hemorrhage of any intensity. In the others it either stopped before the stitches were introduced or after they had been brought together. I don't think that it is of importance what kind of sutures are used. In my next case I shall probably use wire for the crown ones, and silk, prepared according to Dr. Skene's method, for the uterus. The needles are of much greater importance. Dr. Emmet used round ones, but I don't find there is any objection to lancet-pointed needles, and certainly they go in much more easily. It is certainly a great comfort to fix into each lip a tenaculum of some sort, then one gets greater command over the cervix, and can keep it steadier than if a loop of thread or any other means be used.

Dr. Wilson congratulated Dr. Keith on his paper, and remarked that, considering the number of cases operated on the other side of the Atlantic, the midwifery must be somewhat rougher there than on this side.

Dr. Berry Hart did not understand the pathology of the cases operated on, and believed that some forms of inflammatory action went on in the parts. He would like to know the conditions Dr. Keith had met with in split cervix. He had seen pelvic cellulitis and other affections following the operation, and had heard many patients complain that they had not been benefited by the operation.

Dr. Milne Chapman had performed the operation with unfavorable results in four cases. He held that the tendency of Nature to heal the rupture in the cervix caused congestion of the part; this leads to a proliferation of epithelium, which prevented healing. In the one successful case a notable result was the diminution in sub-involuted uterus.

Dr. Barbour had seen eight or ten cases; the benefit derived was only in about one-half of the cases. He, however, held that Emmet's operation was based on sound pathology.

Dr. Arnot (Bombay) thanked Dr. Keith for his paper, and was glad to hear a new operation discussed. He held that the proof of the success of the operation depended not so much upon a good cicatrix, but on the results of a year's experience. How much of the temporary success of the operation depends on the local hemorrhage, relieving congestion, the rest in bed, etc., which accompanied the operation?

Dr. P. A. Young had had no experience of the operation. The operation, he held, received the almost universal assent of the profession. He related a case of chronic split cervix, which was cured by Emmet's operation.

Dr. Brewis recorded five cases treated by Dr. Angus Macdonald, four of which were successful. In the unsuccessful case there was shortening of the broad ligament, which prevented the cervix being drawn down, as was the custom with Dr. Macdonald. There was also some ovaritis. The case at first did well, but on the removal of the sutures it was found that the rent had not been improved. In two cases he had seen severe hemorrhage; he had used a styptic composed of iron, alum, and glycerine, but found the vagina charred, due to the styptic used. This should only be used in hemorrage due to malignant disease. All cases should be watched by the nurse, as severe hemorrhage may come on in any case.

Dr. Webster mentioned a case in his practice where a severe split cervix had been cured by hot water.

Dr. Keith replied that he once held that the operation should be done far more frequently, but he had since modified that opinion. As to the pathology he had formulated no theory. He had operated more because he thought the cervix was at fault. He thought that the operation, as a rule, should not be done in cases of pelvic cellulitis. Dr. Emmet said that the pelvic cellulitis should be first carefully treated, and then the operation might be carefully done.

THOMSEN'S DISEASE.

TRANSLATION BY J. WORKMAN, M.D., TORONTO.

This is a muscular affection, which has been brought into notice by several German physicians and one or two French within the last few years. It has taken its name from the gentleman who, having himself been the subject of it, in common with a large number of his family stock, throughout five generations, was the first to treat of it with

clearness and precision. No less than thirty-five members of the Thomsen kin were known to have been affected with the disorder. Of thirteen children of his mother, seven were found to present it. Hereditary transmission would therefore seem to underlie this morbid form, and it is by no means improbable that it has not been exclusively confined to Germany and France, though, from its rarity and its apparent triviality, it may have failed to attract particular attention. The writer of this notice believes that he has seen, at least, one distinctly marked case in Canada, within the last two years, and it may be that the perusal of the following notice of an article by Longuet, in a Revue critique, in the *Gazette of Military Sanitation*, will lead some of the readers of the LANCET to recall some observances, which at the time of their occurrence wore an anomalous aspect.

The notice above-mentioned is presented in the *Revista Medico-Quirurgica* of Buenos Aires, for May, 1884, of which the following is a translation from the Spanish.

THE DISEASE OF THOMSEN.—In the critical review by Longuet, we have found the following historic details respecting the disease of Thomsen. The subject observed by Leyden was a discharged soldier, who was unable to open his fist when he had shut it; when reading, he was often unable to follow out the lines; the movements of his tongue were impeded; he could not dance or run. In the same year, 1876, Thomsen and Seeligmuller published the first two memoirs on the subject, which were remarkable for their clear and precise conception of the disease. Thomsen, who was not only an observer of the infirmity, but also a sufferer under it, and furnished the first description of it, has given origin to the name by which it is commonly designated in Germany. His own family presented several examples of it, coming down through five generations, in various degrees, and all presenting some form or other of neurotic character. Of thirteen of his mother's children, seven were affected with it. His own children also were affected, though in a mitigated form.

The case recorded by Seeligmuller was that of a recruit, who was a desperation to his drill instructors, because of the slowness and sluggishness of his motions, in spite of his own earnest desire, in the execution of the orders given him. At a later date, Peters, a surgeon major, published his observations of a soldier, 20 years old, who was affected similarly. At the command, "march," he remained immovable, as if rooted to the ground; afterwards, having moved his arms and legs disordinately, he succeeded in starting, but he vacillated for ten or twelve paces before he could attain free movement. He was absolutely unable to run, and if he persisted in the attempt he fell; his tongue and the maxillary muscles shared in the impotency; he could not raise his arms above the horizontal direction.

Westphal presented to the Medical Society of Berlin two patients, one of whom was a student of medicine and a nephew of Thomsen; he had been affected from his infancy. The symptoms are always the same; the functional anomaly may be presented in any of the muscles of the body. One of Westphal's cases showed that after sneezing, the patient could not again open his eyes without great effort, and when eating he could not always shut his mouth when he desired The subjects of the affection have an athletic appearance, but their muscular force is only moderate. Westphal thinks there is a special congenital muscular perversion, coupled with an exaggerated muscular development.

Another recruit has recently attracted the attention of the assistant surgeon major Schonfield. This soldier was sent to hospital because, in his exercise, he suddenly fell to the ground, without any apparent cause. After a rest of ten minutes it was impossible for him to resume the march, at the word of command. He moved with great difficulty, and tottered and fell, rising again only with much difficulty. He had to proceed ten or twelve paces before he could move freely. When he sat down for any time, he could hardly rise again; the torpor, at such times, invaded the upper limbs, as the result of violent exercise. The speech was slow and drawling.

Mobins is the latest writer on the subject. He has published in *Schmidt's Jahrbücher* a very complete analytic review, having personally observed a young student of theology, who was a military volunteer, sent in by surgeon major Sane, who appeared to regard the case as a mimic form of the affection. This youth, after severe fatigue, suddenly became subject to cramps in the calves of his legs, and a stiffness of his limbs which left him powerless for many days. His father presented

the same defects, which were exasperated by the fatigues of military service. After a march, all his movements continued difficult for one or two days. Sometimes the loins were invaded, and after musket exercise, his arms, previously free from the trouble, became affected. The contracture is accompanied by a sensation of tumescence in the muscles attacked; but at other times by a sort of trepidation, like that from faradization; if the leg be extended, the whole limb enters into contracture, and remains for a time unable to bend.

A youth of 22, observed by Berger, presented in his exercise a torpor and rigidity which distracted his drill instructors. The French productions on this subject consist merely of the memoir by Ballet and Mare, published under the inspection of Charcot, and supplemented by a recent article of Mare's, who has given the following details of a case under his own observance. The subject, from early age, found that he had special difficulty in making any movement; when he was in class and was ordered to retire, he could not rise. When called into the army, he exhibited, under examination by the council of revision, the infirmity under which he labored; but the military surgeons did not believe in it; he was however set aside for two years, as of feeble constitution, at the close of which he was admitted. When he went to exercise, it was impossible for him to keep step with his comrades, and he had the like difficulty in managing his arms, as in attempting the motions he was seized with his contractures. The surgeon of his regiment declined to admit him as a patient, and he ordered him to the gymnasium to *soften him down;* but in these exercises also he was attacked with the cramps, and when, for example, he went to mount the wooden horse, he was seized in the moment of the effort, with muscular contracture, and he fell violently against the horse. There is no painful feeling in the muscular contraction.

It is not easy to account for this rare and curious infirmity. Does it consist in a lesion of the medulla, situate perhaps in the lateral cords, or is it a simple functional anomaly of the medullary apparatus? Should the affection be localized in the periphery of the nervous system, or in the muscles? All of these have been hypotheses advanced by different authors, but none of them appear satisfactory. Be it as it may, we have deemed it useful to call the attention of our colleagues to a pathological curiosity which they may perhaps have opportunity to observe. It is well that we should know that a form of nervous disease exists, which consists in *initial transitory muscular spasm, probably hereditary, incurable and independent of any appreciable lesion of the nervous or muscular systems.* Such is the Disease of Thomsen, a designation now accepted both in France and elsewhere.—*La Gaceta de Sanidad Militar.*

THE MODERN OPERATION FOR CATARACT EXTRACTION, WITH CASES.

BY W. TOBIN, F.R.C.S.I., HALIFAX, N. S.

(Read before the Nova Scotia Medical Society).

GENTLEMEN,—I propose bringing before this meeting the notes of some cases of cataract extraction, performed by myself, during the past two years, preceded by a description of the operation.

This operation, in each case, was what is known as the "combined modified linear extraction." It bids fair to become the favorite one with both English and continental surgeons. It consists essentially in an incision confined to corneal tissue, generally made upwards, combined with an iridectomy preceding the opening of the capsule. The instruments required are: a stop speculum—I prefer the one known as the Birmingham pattern,—a fixation forceps, one with a sliding catch being the best—De Wecker's; one of Graefe's narrow bladed knives, about five millimetres in breadth; an iridectomy forceps and scissors and a pricker, to divide the capsule. We may add a hard rubber spatula, also De Wecker's invention, to free the wound from tags of entangled iris or capsule.

The patient's eyes should have been examined, under atropine, some days previous to operation, if possible, and the nature of the cataract and its consistency ascertained; also the condition of the retina as to perception of light. The tension should also be noted and any history of previous inflammatory disease or errors of refraction. The eyelids should be freed, by appropriate treatment, from any pus-producing affection, such as Blepharitis (a frequent cause of flap infection). The steps of the operation are as follows: The patient is placed upon a bed or table with the head slightly raised. An assistant is required to administer chloroform—if an anæsthetic be given it is not

necessary—also to control the patient and to help with the iridectomy. The patient's lids and neighboring parts should be first washed with a disinfecting lotion. The operator's hands and his assistant's, the instruments and the water used, should also be rendered aseptic. It is advisable not to use sponges. A piece of absorbent cotton wool, moistened with boracic acid lotion, which may be discarded when soiled, answers every purpose.

The patient being fully under chloroform, we insert the speculum between the lids and secure it, Seizing a portion of the conjunctiva with our forceps, just below the vertical meridian of the cornea, we draw the globe downwards, and, entering the knife exactly at the sclero-corneal junction, at a point corresponding roughly to the upper margin of the pupil, we pass it slowly and steadily across the anterior chamber on a plane with the iris. Transfixing the opposite point, we carry the blade, with a sawing motion upwards and slightly forwards, making a flap whose summit should reach within a line or so of the corneal border. The assistant now takes the forceps whilst we seize a small portion of the iris and excise it. Resuming the fixation forceps, we pass in the pricker and divide the capsule, making a cross cut, which sometimes brings away a portion of it. Whilst we are doing so, and during the subsequent steps of the operation, the assistant raises and holds suspended over the globe the stop speculum. By pressing on the upper lip of the incision with the spatula and passing a similar instrument from below upwards along the cornea, we start the lens from its bed, and bring it into the lips of the wound, through which it is gently squeezed, perhaps losing some of its cortical matter in transit. The speculum is now withdrawn and the eye closed for a few minutes to allow the chamber to refill. By manipulating the upper lid over the globe surface, we collect the remaining cortical matter in the centre of the pupil, and, reopening the wound, by drawing the eye downwards, cause its escape in the gush of aqueous humor. It now only remains to free our incision from shreds of iris or capsule, with the spatula, to cleanse the globe and sulcus from clots, etc., and to apply the bandage.

I first place upon each eye a piece of lint soaked in boracic acid lotion, then fill up each orbit with layers of cotton wool and tie over all a Moorfield's bandage. This bandage is removed and the dressings changed twelve hours after the operation, and is changed again twice a day for the first week. If all goes well it may then be discarded for a shade and protective glasses. I look at the operated eye (by oblique light, with a convex lens and a candle) on the second or third day. The patient is allowed to sit up after the first twenty-four hours; and to go out within the first ten days, should the weather permit it. The chief points in this operations as contrasted with the old flap extraction are: 1st, the antiseptic precautions; 2nd, the use of the narrow knife, which gives us great freedom in shaping our flap and allows us to correct a faulty incision even after penetrating the cornea; 3rd, by limiting our wound to the cornea, we get one which heals readily and we avoid a conjunctival flap, which by bleeding, etc., would interfere with the next steps of the operation; 4th, by doing an iridectomy, before opening the capsule, we free the iris from pressure during the escape of the lens, besides getting the undoubted prophylactic benefit of the operation—should we wish to be extra cautious the iridectomy may be done some weeks beforehand. 5th. The operation may be done without an anæsthetic—De Wecker never gives one, having once lost a patient under chloroform. The use of the spatula is also to be noted in cleansing the wound. Here eserine, as a pupil-contractor, may be also of service. Lastly I would draw your attention to our early examination of the wounded eye by non-irritating oblique light, and to the lessened confinement both to bed and to the house of our patient.

I enjoin a few cases illustrative of this method of operating.

Case I.—Mrs. McC., aged 70, residence, Chester. Double senile cataract, complete in both eyes; a dyspeptic subject. Operated on right eye, assisted by Dr. Farrell. Made usual incision upwards. When about to extract the lens the patient showed signs of chloroform collapse. The operation had to be suspended till she was restored by artificial respiration and subcutaneous injections of brandy and ether. On recovery, the lens (hard, dark and small) came away easily. The eye was cleaned and the bandage adjusted. All went well till the sixth day, the patient then sitting up and using protective glasses. She incautiously removed them and a prolonged exposure to light brought on a sharp attack of iritis, with opacities

in the anterior chamber and vitreous. From this attack she made a tedious recovery. The treatment consisted in hot fomentations of belladonna and inunctions of mercurial ointment and belladonna extract with tonics and sedatives internally. However, in a month she was able to return home. The eye quieted down and the opacities were absorbed. Vision, which had been clear twelve hours after the operation, was restored, and she now sees fairly with the usual glasses.

CASE II.—Miss B., aged 55 years; residence, Halifax. Double senile cataract; complete in right eye, incomplete in left. An anterior synechia, the result of old iritis in the right. Operated upon the eye in Sept., 1883, assisted by Dr. Lawson. The usual corneal incision was made followed by a large iridectomy. The lens was found too large for the wound, which required a slight cut to free it. A portion of capsule adherent to the synechia obstructed the new pupil, but not seriously interfering with vision was allowed to remain. The bandages were removed within a week and recovery with good vision ensued without a bad eye symptom, though she suffered severely from rheumatism. She now sees well at a distance and can read with the usual glasses.

CASE III.—Mrs. C., aged 60; residence, Chester. Double senile cataract; mature in both eyes. Right some years, left one year. Can distinguish light from darkness. Operated on right eye 19th October, 1883, assisted by Surgeon-Major Orwin. Made the usual corneal incision, which in this case, however, was carried too far upwards, involving a conjunctival flap which bridged the incision (remaining uncut), bled freely, and obstructed the operation. In making the iridectomy the lens capsule was ruptured and the lens presented immediately. The conjunctival bridge was divided and the lens extracted; but from the incomplete division of the capsule this membrane had not retracted and occluded the pupil. An attempt was made to extract it with the forceps, but in doing so the posterior capsule was wounded, and there ensued a loss of vitreous. The wound was at once closed, and the eye was tied up with a compressive bandage. This was left unchanged for 48 hours up to which time there was no pain or uneasiness. The wound was then found healed and retained the aqueous. Pain followed, however, the reapplication of the bandage, and decided iritis followed before the fifth day, shown by contracted pupil, haziness of anterior chamber, dimness of vision and pain over eyebrow. The iritis was treated in the usual way, by atropine instillations, hot fomentations of belladonna and mercurial inunctions, tonics and sedatives internally. In spite of all treatment, however, the pupil became contracted and updrawn, and when she left town, some six weeks afterwards, the eye was still irritable and vision was reduced to the counting of fingers. I have seen her quite lately (six months after the operation). The eye is quiet, the pupil V shaped and updrawn, but part of it is clear of capsule. She can find her way about the house, sees fairly at distance, and with glasses can read the large print of a newspaper. This case shows the troubles which follow a conjunctival flap. It also shows that it is better to leave the capsule behind, trusting to a secondary operation to clear it, rather than risk a loss of vitreous, by trying, injudiciously, to remove it.

CASE IV.—Mr. G., aged 62. Double senile cataract; mature in both eyes. A free liver who had suffered in his time from malaria. Operated on left eye on 21st April, 1884, assisted by Dr. T. Almon. The usual combined operation was done under chloroform, and the lens came away easily, on the end of the pricker. He suffered severely from pain, with great conjunctival inflammation during the first week, which I was at a loss to account for, till I found him considerably the worse for liquor, when visiting him with Dr. Almon, the sixth day after the operation. The eye became acutely inflamed, with chemosis, contracted pupil and dimness of vision. He was treated with solutions of boracic acid and atropine instillations. Stimulants (which had been allowed in moderation from the beginning) were withheld altogether, and a week after he was up and seeing clearly. I had a visit from him to-day (6th July) to fit him with glasses. The pupil is clear, key-hole in shape, and admits of good vision. With + 8 D. he sees well at distance (V=⅔ De Wecker's types), with + 14 D. he can read the smallest type in the text book.

CASE V.—Mr. D., aged 55; residence, Newfoundland. Double senile cataract; mature in both eyes, right eye one year, left 8 years. Operated on left on 4th June assisted by Dr. T. Almon. A small, low-placed corneal incision, such as that

recommended by Lubrech—done upwards and confined to the cornea. The lens on presenting was caught by upper section of wound. By pressing this down with the spatula it escaped easily. No other complication attended or followed the operation. On the 3rd day I examined the eye. The wound was healed and the cornea clear. On the 5th the bandages were removed, and a floating shade of black cloth replaced them. On the 8th he was allowed protective glasses and was able to leave the house, with the eye well guarded from light and dust, to take exercise. At the end of the month I fitted him with glasses. With + 8 D. vision=⅔ (reads De Wecker No. 7 at distance) with + 12 D. reads clearly newspaper type at 10 inches.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—The following questions have occurred to me in an hour or two of leisure, and are submitted for consideration, not that they present any new features, for undoubtedly every physician in ordinary practice has mentally asked the same, but to show some prevalent faults and to draw attention to matters pertaining to the welfare of our profession. Besides, it was thought that they would be a departure from the ordinary and monotonous style of medical reading so constantly subjected to our notice.

I. Why are there so many physicians engaged in other employments outside of their profession, who delight in a semi-philanthropic practice to the discouragement of others who endeavor to excel in, and who live solely by their profession?

II. Why are there so many among us who, in consideration of their length of practice, seem to deem it an honor to subscribe to the virtues of "Domestic Medicines," "Every Man his own Doctor," "Household Physician," and similar works?

III. Why is it that now and then a physician in good health, and doing (as he says) a $3,000 or $4,000 a year practice, will accept a position which brings in one-half or less of the above?

IV. Why do some Physician-Druggists allow themselves to act as vendors of such remedies as "Sir Jas. Clarke's" and "Lady Huntingdon's" female pills, which are directed to be used with caution (?) at certain times?

V. Why do ministers of the gospel whom we, as a rule, attend without any pecuniary reward, whenever occasion presents itself at the bedside of one of their flock, interfere with the instructions of the physician, or tell about some similar cases wherein different treatment was beneficially used?

VI. Why is it that among these same reverend gentlemen there exist some who, without admitting any medical knowledge or having pursued medical studies, insult the regular profession with announcements of some specific "croup and diphtheria" compound, life saving pill or compound?

VII. Who is to blame for the ignorance existing among the public in regard to the distinction between patent medicines and well established therapuetical preparations, and where is there a man outside of the fraternity or drug business who understands why we prescribe Syr. Hypophosph. Co. (Fellows) and not "Dandelion Blood Purifier"?

VIII. Do our young physicians go to Europe for extra degrees or extra knowledge?

IX. Are not our nauseous and muddy mixtures advancing the interests of Homeopathy and the patent medicine business?

X. Why as a rule do many of our town and village brethren keep such filthy offices, filthy bottles of all sizes, colors, and shapes (pickle bottles are not uncommonly noticeable), when they know that neatness, cleanliness and order pay well?

"An' then a' doctors' saws and whittles
Of a' dimensions, shapes, an' mettles,
A' kind of boxes, mugs, an' bottles
He's sure to hae;
Their Latin names as fast he rattles
As A. B. C."

XI. Is there a physician of several years' practice who will deny the utility of a series of lectures to a graduating class pertaining to the ordinary duties and obligations of the profession to itself, and the public—and other minor details of a purely practical and business order, which so many of us have learned by sad experience and needless expense?

Yours, etc.,

QUEROR.

September 21st.

Reports of Societies.

HURON MEDICAL ASSOCIATION.

Oct. 7th, 1884.

Dr. Campbell, of Seaforth, presented a case of empyæma, in a boy 15 years of age, on which he had operated, first by aspiration, and after by free incision, removing, on the 29th May, six pints of sweet pus, and on the 12th June following, eight pints of fœtid pus, by an incision three inches below the angle of the scapula. This was necessary on account of the distressing dyspnœa. Dr. C. was assisted by Dr. Elliott, of Brucefield. The treatment was, antiseptics locally, and syrup of the iodide of iron and Scott's emulsion constitutionally. Dr. C. also reported a case of puerperal eclampsia at eight months. Labor was induced, and delivery by forceps. The convulsions increased in frequency and violence until one-fourth of a grain of pilocarpine was injected hypodermically the second time, when recovery took place.

Drs. Gunn & Elliott presented a case of cirrhosis of the liver in a man 63 years of age. About two months ago he vomited nearly two quarts of blood and has not been well since. The question of cirrhosis was discussed, some thinking that it might be cancer of the stomach. The spleen, on percussion, appeared to be enlarged, and an incurable eczematous eruption covered his chest and face. Drs. G. and E. also showed a case of peculiar nervous hiccough connected with absence of menstruation, which has been in progress about four months, during three of which considerable vomiting was present. The hiccough is constant except when sleeping, and amounts to from 60 to 100 hiccoughs per minute.

Dr. Williams presented a case of blindness of both eyes from congestive amaurosis. The left eye became blind three years ago, and in the last week the other eye became blind in about three days.

Dr. Nichol, Bayfield, read a very interesting report of a case of traumatic tetanus, terminating fatally, produced by a gunshot wound of the thigh. The charge of shot had been in the wound three weeks when he first saw the patient, and tetanus had existed four days without treatment. The probe passed its whole length, and a counter opening was made to facilitate discharge. Any manipulation of the wound at once produced a spasm. He died on the eighth day, twelve days after the tetanus began, and thirty-three days after the accident. Chloral hydrate appeared to be the only remedy that controlled the spasms. The question arose as to whether the charge of shot could not have been extracted and the young man's life saved. At the post mortem the charge was found a little beyond where the probe had reached, and a little perseverance in the early part of the difficulty might have found and extracted the shot by a counter incision.

Dr. Worthington, of Clinton, showed a case of compound fracture of the third metacarpal bone of the right hand, produced by a dull adze, the finger being shortened one-fourth of an inch. A method of extension was devised, and the wound was treated with boracic acid gauze. The wound united by first intention, and the patient suffered no pain from the first.

Some cases of ulceration of the leg were shown after typhoid fever, and a peculiar case of eczematous inflammation of the leg of long standing.

Selected Articles.

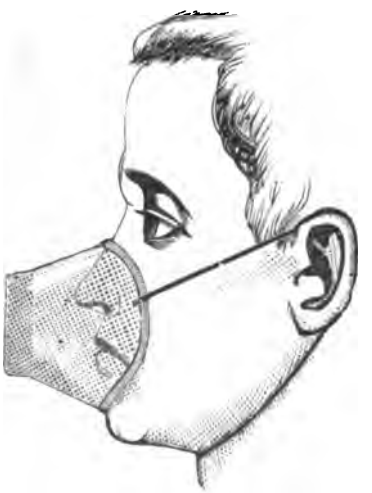
THE YEO RESPIRATOR.

Dr. S. Cohen, M.D., of Philadelphia, gives the following in the *Medical News*, Oct. 11th :—

Continuous inhalation of a volatile medicament by means of an apparatus worn over the nose and mouth—a so-called "*respirator*"—is by no means a novel idea ; but the cost and clumsiness of most of the appliances devised for the purpose have until recently prevented this method of treatment from being carried out upon a sufficiently extended scale to afford a reliable test of its efficiency. Dr. I. Burney Yeo, of London, described and figured in the *British Medical Journal*, for July 1, 1882, a respirator constructed of perforated zinc bound with chamois skin, shaped to cover both nose and mouth, which carries a sponge upon which the medicament desired to be inhaled can be dropped, and which is retained in position by means of a pair of elastic loops passed around the ears. The lightness of this appliance, its cheapness, and its cleanliness, commend it as the best device for the purpose yet offered to the profession. Until within a few months it has been impossible to obtain the respirators in this country, and those used in the cases upon which this article is based, were imported. Messrs. Wyeth & Bro., of this city, are now manufacturing them, however, with a slight

change in style suggested by Dr. J. Solis Cohen. This modification consists in placing the sponge within a little cage formed by a fold of zinc in the front of the respirator, instead of retaining it in position by elastic bands.

The material of which the respirator is made being pliable, it can be accurately fitted to the face. The shape being adjusted, the sponge is wetted with hot or boiling water, and the medicament dropped upon it. The respirator is then fastened around the ears, and worn for such period as may be directed by the physician, or practicable for the patient. In many cases, the patient being engaged in his business occupations during the day, will consent to wear the respirator at night only. Some patients can sleep in them, others find it impossible to do so. The following are the substances



recommended by Dr. Yeo for inhalation; creasote, liquefied carbolic acid, spirits of turpentine, eucalyptus oil, terebene, spirits of camphor, solution of tar in rectified spirit, tincture of benzoin, and tincture of iodine. He uses of these five minims, either alone or mixed with an equal quantity of spirits of chloroform. Of course, any drug volatile at ordinary temperatures can be employed, but the list given by Dr. Yeo embraces nearly all which have been found of value in daily practice. I would add to it, however, chloroform, iodide of ethyl, and the alcoholic solutions of thymol and of menthol. Dr. Yeo's principal resort to treatment by the respirator has been in cases of phthisis, in which he has desired to keep up a continuous antiseptic inhalation; and the drug which he has found of the most service is creasote. From this treatment, in conjunction with proper hygienic measures and constitutional medication, he has obtained excellent results, some of which he has reported.

Dr. J. S. Cohen and myself have tested the method during the past two years at the German Hospital, at the Philadelphia Polyclinic, and in private practice. The cases selected for this purpose number more than one hundred and fifty. While our results do not justify the endorsement of the plan as in any sense curative of phthisis, they have convinced us that much comfort may be afforded to patients past cure; that distressing symptoms may be quickly relieved, and in some instances entirely removed; and that recovery may be aided in cases affording reasonable basis for favorable prognosis. In other diseases of the respiratory organs, there has seemed to be a hastening of the favorable termination in some instances, and a marked degree of relief in others, even in chronic and incurable affections. Without detailing histories of cases the following general results may be recorded:

In Phthisis.—In cases with slight laryngeal involvement, the inhalation of terebene (ten drops, renewed every second or third hour) as continuously as possible during the day, with the addition of chloroform (five drops at bedtime) during the night, has seemed to allay the uncomfortable sensations of dryness and heat in the throat, and to restrain irritative cough. The relief has been particularly marked, and the gratitude of patients correspondingly great in cases in which, prior to the institution of treatment, sleep had been disturbed by violent spells of coughing two or three times during the night. In those cases in which the absence of a hemorrhagic tendency has permitted the use of daily inhalations of compressed air, after the increased coughing and expectoration caused by the loosening of retained and impacted secretions has subsided, there has been almost entire cessation of coughing. At most, in some instances, there has been a "clearing-out" cough on arising in the morning, and in but one or two instances has an unproductive cough remained during the day or night. In dispensary practice, oil of turpentine (twenty drops) has been prescribed instead of the terebene, with almost equally satisfactory results. In some cases, however, especially those in which there has been organic lesion or functional disturbance of the kidneys, terebene and turpentine have caused distressing symptoms referred to the back of the head and to the ears, and apparently due to cerebral congestion. Many patients, even among those whose disease has already proved fatal, have declared that they could not be induced to part with "the little machine." In one case, which I shall at some future time report in full, the patient, a girl of eighteen years, complained that the dose of chloroform (three minims) ordered at bedtime, "smothered her." On increasing the dose to five minims, the unpleasant sensations disappeared, and she fell almost immediately, upon retiring, into a refreshing sleep, undisturbed by the cough that had formerly harassed her throughout the night. While it is only fair to add that in this

case there was a constant and remarkable improvement in every respect under constitutional treatment, yet the relief to cough preceded other favorable changes.

In cases with marked laryngeal disease, the amelioration produced by treatment with the respirator, while decided, has not been so great as in the preceding group of cases. These patients have, as a rule, done better under creasote than under terebene; and where there has been extensive ulceration, eucalyptol seems to have done more good than either of the other drugs. Eucalyptol, however, has been on the whole a very disappointing and unreliable drug, failing utterly in some instances, and as yet, without affording any positive indications as to the conditions in which it is likely to prove of service. Whatever drug has been employed in this group of cases, whether terebene, turpentine, thymol, creasote, or eucalyptol, the best results have been obtained from its admixture with chloroform or with spirits of chloroform; chloroform alone being used at night.

In Bronchitis.—In subacute and in chronic bronchitis, good results have been obtained from the use of the Yeo respirator, worn for an hour or two at a time, during the day and night, with terebene, spirits of turpentine, or tincture of benzoin, as the medicament. In bronchorrhœa and in fetid bronchitis, creasote and carbolic acid have been advantageously employed, either singly or in connection with one of the other remedies. Eucalyptol has been of value in a few cases. Ethyl iodide has given excellent results in cases of profuse bronchorrhœa. Even in a few instances of pulmonary gangrene, the fetor has been controlled by this drug, after failure of other remedies. In most instances, cough has been restrained and expectoration has been diminished in amount and corrected in character; while the subjective relief afforded has often been most gratifying.

In Chronic Laryngitis and Tracheitis.—In cases of chronic laryngitis in which burning or tickling sensations in the throat, or annoying cough, have constituted sources of distress, terebene, creasote, camphor, and tincture of benzoin have proved very useful. Eucalyptol has succeeded where the other remedies have not answered a good purpose; but has not been at all reliable. It must be used, if at all, in small quantity (two or three minims on the sponge at a time) or well diluted. The benefit of inhalation by means of the respirator has been most marked in cases of laryngo-tracheitis characterized by a constant desire to hawk out something that seems to stick in the upper part of the trachea; a purely subjective sensation. In these cases terebene has been chiefly used, but tar has also seemed to be beneficial.

FIBROID TUMORS—DYSMENORRHŒA—RAPID DILATATION.

CLINIC BY DR. GOODELL.

GENTLEMEN:—The first case is one which comes for diagnosis. The patient is a colored woman, 45 years of age, who has been married sixteen years, and had seven children, the youngest of which is five years old. She has not seen the menses for over one month. Previous to this they had been coming every two weeks, and were profuse. If she were an unmarried woman, or married and sterile, I should say that she either had a fibroid tumor or a polypus. But as she is a married woman and has children, then I would say, if she were white, that most likely she had carcinoma. On the other hand, she is a colored woman, and I have never yet seen carcinoma of the neck of the womb in a colored woman. We therefore come to the conclusion that she has some growth which causes the bleeding. The diagnosis lies between the rare disease of cancer and fibroid tumor. It is true that the bleeding might be due to fungous vegetations, but usually these do not cause bleeding every two weeks They produce menorrhagia, with a profuse leucorrhœa between the periods. It might be a malignant growth within the cavity of the womb, but this is rare.

We shall now make the vaginal examination. The womb is decidedly larger than it should be, and on its posterior surface I feel a number of disseminated nodules. This is evidently a case of multiple fibroids. I had expected to find a tumor of some magnitude. The sound gives a measurement of 3.5 inches. I can feel the left ovary, which is hard, enlarged, roughened, and hardened. This is interstitial or parenchymatous degeneration, the result of ovaritis, and is not uncommon. I have never seen but one ovarian tumor in a colored woman, and that was in a mulatto. I can touch without much difficulty the promontory of the sacrum. She states that all the labors were hard, but that instruments were only used in the next to the last labor, and that all her children were very large. I can trace the sacrum all the way from the coccyx to the promontory. When you can touch the promontory of the sacrum with the finger, you may be sure that the pelvis is contracted. The promontory can be reached more readily in those cases in which the perineum is relaxed or torn. In this case the perineum is torn down to the sphincter.

Here is a woman whose womb measures three and a half inches, who has fibroid nodules in the posterior wall of the uterus, and also a laceration of the perineum. This latter, however, is not sufficient to demand the operation. She is not suffering enough to demand the operation. The change of life is coming on, and the nodules are not large

enough to warrant the idea that she is going to lose much blood. There has been an interval of a month since the last period, and perhaps the next may be longer than a month. We shall order for her ten grains of chloride of ammonium, and twenty drops of fluid extract of ergot three times a day. She will return in the course of a month, and report results.

The immunity of the colored race from cancer of the uterus is rather remarkable. Some of the southern physicians say that they have seen cancer in the colored race, but not so commonly as among the white race. They have another form of disease which the whites rarely have, that is keloid disease of the skin. I have seen this a number of times in colored people, but only once in the white race. Colored women are, however very subject to fibroid tumors of the uterus. It is rare to find a fibroid tumor in a white woman before the age of thirty-five years, but in sterile colored women from the age of twenty to thirty-five, they will be found quite frequently. These tumors do not cause death, although a physician who sees a great many of these cases has to operate occasionally. In a case which I saw the other day, I found a fibroid tumor as large as a man's head in an unmarried woman of thirty-nine. She is losing a great deal of blood, it is an anxious question to decide what is best to be done. Her physician states that during the past few months it has been growing rapidly. Now a fibroid tumor which increases rapidly in size may become so large as to interfere with any operation.

In operating for fibroid tumor of the uterus an exploratory incision is made, and if the tumor is found to have a pedicle, this is tied and the tumor removed and the wound closed, just as in the removal of an ovarian tumor; and this ought to be as successful an operation as removal of ovarian tumors. It is, however rare to find a fibroid tumor with a pedicle. They usually spring directly from the womb. When this is the case, the proper plan is to remove the ovaries, which is a simple operation. By so doing, not only is menstruation stopped, but large blood vessels passing to the uterus are ligated, and in this way the blood supply is to a great extent shut off from the tumor, and in the great majority of cases it will diminish greatly in size. I have performed the operation a number of times, and have failed to check the hemorrhage in only one instance, and in this case the tumor proved to be malignant. If the tumor is allowed to become too large, it may render the operation impossible. Two years ago I operated on an enormous fibroid tumor in a white woman of thirty. I had seen her a year previously and had urged the operation, but she preferred to wait. At the time of the operation the tumor filled the abdominal cavity, and must have weighed forty pounds. I had to make the incision from the ensiform cartilage to the symphisis in order to get the tumor out of the abdomen. The ovaries were attached to the tumor, and one of them was stretched to a length of six inches. It was a very serious operation, and the girl died in forty-eight hours. I have always regretted that I did not remove the womb in that case, although the result might have been the same. When the tumor is not large, it is possible to get at the ovaries without much difficulty. In these cases the ovaries and Fallopian tubes will as a rule, be found to be diseased. Very often the tubes are cystic. When the ovary is affected it is often a follicular degeneration in which the capsule is thickened and the follicles are enlarged and project from the surface, or else an interstitial degeneration in which the organ is enlarged, roughened, and hardened, cirrhotic in character.

DYSMENORRHŒA: RAPID DILATATION.

Here is a patient thirty-one years of age, married and sterile, who has had a great deal of pain since the time of puberty. This has been so bad as to incapacitate her for work, and it has been growing worse and worse. Why should she have pain, and why should it grow worse? If an unmarried woman, or a woman who is married and sterile, comes to you with a history of dysmenorrhœa, what should pass through your mind? That it is a dysmenorrhœa from anteflexion; that it is due to a stenosis caused by the womb bending too sharply towards the front—towards the front because she has never born children, and the natural position is slight anteflexion. This is an exaggerated condition. There are very few exceptions to this rule. Sometimes there is retroflexion. As a rule, you will find anteflexion. The dysmenorrhœa is mechanical, and usually gets worse after marriage. The woman may have been able to get along pretty comfortably before marriage, but afterwards the pain becomes worse and worse. Nature intended that when a woman got married she should become pregnant, and if a married woman does not have children, she nearly always suffers. The pain of dysmenorrhæa, due to stenosis, is usually of that character. It gradually becomes worse until it culminates, and when it reaches the highest point, there is a sndden gush and the pain subsides. Then it begins again and reaches another culmination, which is followed by a gush and relief. The womb is bent. The menstrual blood tries to overcome the bend, but it cannot do so until it has straightened the womb. After the womb is sufficiently distended to remove the bent condition of its neck, there is a sudden gush of fluid followed by relief. The same thing is seen when a rubber tube is bent; the water flows through the tube until it reaches the bent portion, when it is arrested until the force behind becomes sufficient to straighten the bend, and thus overcome the obstruction. The pain is due, not only to distension of the womb, but also

to the efforts of the organ to force the blood out of its cavity. This causes thickening of the endometrium, which in turn tends to increase the difficulty. When a woman suffering with this form of dysmenorrhœa gets married and does not bear children, the congestions arising from sexual intercourse will cause greater thickening and hypertrophy of the lining membrane of the womb, and consequently the cervical canal becomes still more contracted. There is not only thickening of the endometrium, but also hypertrophy of the parenchymatous structure of the womb. Then there is congestion of the ovaries and structural changes following on this congestion. These changes may either result in follicular or interstitial degeneration.

I shall now make a physicial examination. The first thing I detect is a virginal cervix. It is not thicker than my little finger. The os is very small. With a little manipulation, I get the sound past the bend and obtain the measusement of three and a quarter inches. This increased length of the womb has been produced by the dysmenorrhœa. I propose to operate for this trouble by forcibly dilating the neck of the womb. The cutting operation is the one usually recommended in the books, but that is a dangerous operation, and is by no means as successful as forcible dilatation. I have notes of one hundred and fifty cases in which I have performed this operation, and there has not been one fatal result, and in but one or two has there been any pelvic inflammation. To show you the result of the operation, let me refer you to a case on which I operated a number of years ago. A clergyman's wife came to me suffering greatly with dysmenorrhœa. She had been married several years, and was sterile. I dilated the canal and heard no more of the case until a few days ago, when I saw her physician who told me that after the operation she had gone home, and the first year had twins and has been having children ever since. I have had a number of such cases, in which pregnancy followed the operation. In the majority of cases, it is not necessary to perform the operation more than once, provided it is done thoroughly under ether. Women often object to taking ether, and want me to do it in my office without ether. I always tell such patients that the operation gives a great deal of pain, has to be repeated frequently, and is very imperfectly performed under such circumstances. I tell them of the man who had a dog of which he was very fond. The dog had a long tail greatly disfiguring him. The tail had to be cut off, but the owner of the dog disliked to give the dog so much pain—he therefore concluded to take off an inch a day until a sufficient length had been removed.

I shall first take this Ellinger's dilator and tunnel my way into the womb. First, introducing the dilator as far as it will go and dilating to that point, then pushing it a litte farther, I again dilate, and in a few minutes the instrument passes the internal os. Sometimes when the os is too small to admit the entrance of the dilator, I enlarge it with the scissors, keeping the blades closed, and using them with a boring motion. As I remove the dilator, you observe that a quantity of thick mucous follows its withdrawal. Whenever this is seen it is an evidence of obstruction. I shall now introduce the larger Wilson's dilator. In buying a dilator of this kind, you should be sure to see that it has these little shoulders on the blades to prevent it from slipping too far into the uterus ; for if the blades should come in contact with the fundus of the womb and be separated in that position, there would be risk of producing serious injury. After dilating up to a certain point, I wait a while. In all the cervices that I have dilated, I have torn only two. One was in a virgin and produced a slight laceration. The other was in a case which had been treated by the application of nitrate of silver until the tissues had been made brittle by the formation of cicatricial tissue. In that case a slight laceration was produced, and the bleeding was free enough to require the application of Monsel's solution. That is the only case in which I found it necessary to apply any styptic. Sometimes I get hold of a very small cervix, one which is really infantile. Under such circumstances I do not expand the instrument to its fullest capacity, for fear that I may tear the cervix. In the majority of cases, however, I dilate to the fullest extent of the instrument. This gives an os through which the finger may be passed to examine the interior of the womb, and in many cases this is better than dilating with sponge tents. There is not the same danger as exists with sponge tents. On the other hand, tents will dilate to a greater extent. After a dilatation of this kind I can often introduce my finger into the womb, although I am not usually able to do so in sterile cases. I have now separated the blades of the dilator to their fullest extent. I shall remove the ether and allow the instrument to remain until the woman begins to flinch. Just before beginning the operation, I introduce a suppository of one grain of the aqueous extract of opium into the rectum, so that by the time the operation is completed the suppository will have dissolved and the opium be absorbed. At first the pain is great, but it soon subsides. Usually two suppositories are all that is required, one being given at the time of operating, the other two hours afterwards. If the pain continues, the opiate must be repeated. If there is much soreness, I have a poultice placed over the abdomen. I always like to keep these patients in bed for forty-eight hours. For the first twenty-four hours I order a light diet, and after that the patient returns to her ordinary food. If the soreness continues, I keep them in bed until it disappears. The woman is now beginning to show evidence of feeling the pain, and I

shall remove the dilator. It is very probable that some of the muscular fibres have been ruptured. I know that some of them have been over-stretched and will never contract as before. There is, as you see, a little oozing of blood, but I shall not attempt to check this, for I consider a little bleeding an advantage, as it tends to prevent the occurrence of inflammation. I have never had severe metritis or peritonitis after this operation. I have, however, seen slight localized inflammation follow it.

You will often be consulted by sterile women who want to have children. It is a mania with them. If a woman wants to have children, she will go through fire and water to become pregnant; and on the other, hand, if she does not want to have children, which I am sorry to say is the crying evil of the day, she will go through fire and water to prevent conception. If a woman wants children, all her friends know of it. Sometimes this operation will enable such a woman to become pregnant. At times, however, the condition has lasted so long that changes in the uterus have been induced which effectually prevent conception. If you are fortunate enough to enable her to have children, she will blazon your name and skill all over the neighborhood. If this operation is done carefully, I can recommend it most confidently. It is much safer and far more successful than the cutting operation, which I am happy to say is now rarely performed. —*Med. and Surg. Reporter.*

WOUNDS OF THE INTESTINE—GROSS.

* * The diagnosis of wounds of the bowel is a matter of primary consideration, as upon its prompt determination the success of our treatment must mainly hinge. The possibility of this will, of course, mainly depend upon the situation in which the bowel is found at the time of the accident. If it has escaped through the wall of the abdomen it will generally be easy to find the injured part by the egress of some of its contents, as fæces, mucus, or bile, or all these together; and so also when there is a discharge of some, or all, of these substances through the outer wound, although there be no protrusion of the intestine. The coast in both of these conditions is sufficiently clear; so clear, indeed, that he who runs may read and accurately interpret. But it is altogether different when the abdomen has been pierced with a narrow instrument, as a knife or a dirk, or perforated by a bullet. In such an event the bowel does not protrude, and hence the true nature of the case must be solely a matter of conjecture. All that is positively certain in such event is that there is a wound in the wall of the abdomen. The surgeon, especially if called immediately or soon after the receipt of the injury, must be in doubt whether the weapon has entered the bowel or not. In reflecting upon the subject he recalls the fact that a bullet, a rapier, a sword, or a ramrod has occasionally passed through the abdomen, and, perhaps, even emerged at the opposite side, without in the slightest degree interfering with any of its contents. The records of surgery furnish many such cases.

The two principal signs which must serve to guide us in these uncertain cases are tympanites and a discharge of blood by the anus. The occurrence of tympanites is unquestionably a symptom of great value. Jobert, who was the first to notice it, regards it as the most reliable of all the phenomena when there is no escape of fæces, mucus, bile, or other fluid at the abdominal wound, and in this opinion the results of my personal observation fully coincide. The tympanites supervenes at various periods; sometimes almost immediately after the wound in the bowel has been received, and is then always of proportionate diagnostic value; at other times it supervenes very gradually, and in some cases, again, it does not make its appearance under twenty-four, thirty, or thirty-six hours. However this may be, it is always diffused, not circumscribed, and sometimes reaches an enormous height, the belly emitting a hollow, drum-like sound on percussion, and is then always very painful.

Although tympanites is generally present in lesions of this kind, there are cases in which it is entirely absent; as, for example, when the wound in the bowel amounts to a mere puncture, in which the opening is effectually closed by the protrusion of the mucous membrane, thereby preventing all escape of gas into the peritoneal cavity.

A discharge of blood by the anus I regard as a very valuable symptom of the existence of a wound in the bowel. It is especially valuable when it makes its appearance within a short time after the infliction of the external wound, and when it continues, more or less abundantly, for some days afterwards. As the blood is always intermixed with the contents of the bowels, it seldom comes away in a pure state, but is generally of a dark color, and of a grumous consistence.

No useful conclusions can be deduced from the shock and the pain which attend lesions of this character, since both vary greatly in different cases and in different circumstances, some persons suffering very little, while others, owing to the pecularities of their nervous endowments, experience extreme distress.

In regard to probing wounds of this kind, the universal sentiment of the profession is opposed to it, on the ground that, while it can do no good, it would often be productive of great harm, by disturbing the relation of parts, and thus endangering fæcal effusion. I do not think, however, that this rule should apply to the mural wound. Here a probe, properly used, might at least afford useful

information in regard to the direction and extent of the external injury.

In the treatment of wounds of the intestines two leading indications are scrupulously to be kept in view—the prevention of fecal effusion, and occurrence of peritonitis. To secure the first, the only safeguard is efficient suturing of the wound. A case, it is true, occasionally recovers without any precaution of this kind, but this is owing to good luck rather than to good treatment. The question here naturally arises, should all wounds of the bowel, however small, be sutured? Upon this subject there was certainly till recently, if indeed there is not still, some diversity of opinion. Dionis, Palfin, Heister, and Sabatier state that enterrorhaphy is unnecessary when the wound does not exceed the diameter of a goose-quill or a penknife; and views of a similar nature are to be found in other writers, as Sharp, Richerand, Boyer, and Jobert. On the other hand, there are surgeons who are opposed to the return of the bowel into the peritoneal cavity, however small the intestinal wound, without the employment of sutures, lest fecal extravasation should ensue. The great Benjamin Bell, of Edinburgh, writing near the close of the last century, holds, in the midst of the darkness that surrounded him, the following emphatic language: "However small a wound of the intestine may be, it ought always to be secured with ligature; for, although it is alleged by some that we should rather trust to nature for the cure of a small opening than to insert a ligature, to me it appears that the opinion is by no means well founded, insomuch that I would not leave even the smallest opening, that could admit either fæces or chyle to pass, without stitching it up. Much danger may ensue from omitting it, and the hazard of the patient cannot be increased by the practice being adopted." This advice of the sagacious Scotchman, so clearly and emphatically enunciated nearly a century ago, is now the universal practice in all cases of wounds of the bowel, however diminutive, based as it is upon the well-ascertained fact that enterrorhaphy, when properly performed, is a harmless operation as compared with the risk of fecal extravasation and the consequent certainty of peritonitis.

Judging from the results of my own observations, I have long been of the opinion that there are only two sutures that should ever be employed in sewing up a wounded bowel. These are the continued and interrupted, with the modifications of the latter by Lembert and Gély. As to Jobert's method, which consists in invaginating the ends of the bowel, when completely cut across, so as to place the two serous surfaces in immediate contact, to facilitate their prompt union, the operation is not only extremely difficult, but very liable, even if successful, to be followed by more or less contraction of the tube at the seat of the injury, thereby interfering more or less seriously with the transmission of its contents.

The interrupted suture is, as a rule, preferable to the continued, in all wounds of the bowel, whatever their extent or direction, whether they embrace the entire calibre of the tube or only a limited portion, and whether they are circular, oblique, or longitudinal. The operation executed with a long, slender sewing-needle armed with a thin, but strong, well waxed silk thread, is comparatively simple, affords ample security against fecal effusion, and is never followed by injurious contraction of the tube. The sutures should be placed not more than one line and a half, or the eighth of an inch, apart, and the ends, tied in a double knot, should be cut off close, so that in time the sutures may find their way into the bowel and be discharged along with its contents. I deem it very important that each suture should be fully one line from the edge of the wound, and that the needle should be passed deeply through the wall of the bowel instead of embracing its entire thickness—an arrangement which would almost inevitably be followed by more or less puckering, and by the consequent retardation of the cure. The operation of uniting the bowel where the division is complete, will be greatly facilitated if the first suture be inserted at the mesentery and the second immediately opposite. The best, certainly the safest, ligature for suturing a wounded intestine is ordinary sewing *silk*, well waxed, and inserted with a long, sharp sewing-needle. The carbolized catgut ligature is liable to give way prematurely, and should, therefore, be avoided.

In the modification of this suture by Lembert, the object is to invert the edges of the wound so as to bring the two serous surfaces in immediate and firm contact, to establish, as it were, union by the first intention. Great advantage has been claimed for this form of suture, but this is not so apparent when it is remembered that, unless great care be taken in introducing it is liable to be followed by more or less contraction of the tube. In making this suture the needle makes two dips on each side of the wound instead of one, as in the ordinary procedure.

"Gély's suture, which is merely a modification of that of Lembert's, is made with two needles inserted near the angle of the wound, about one line from its edge; they are then carried along the interior of the bowel, parallel with the wound, for the sixth of an inch, when they are brought out precisely at the same level, so as to appear again on the peritoneal surface. The threads are then crossed, the right needle being passed through the puncture made by the left, and conversely, when the ends are firmly tied and cut off close, as in the ordinary operation. The number of sutures varies, of course, according to the extent of the cut. I this way the edges of the wouud are thoroughly in-

verted, and consequently all danger of fecal effusion is prevented: the coaptation, in fact, is so accurate as to conceal the ligatures.

The treatment of wounds of bowel by the continued suture has afforded good results in my experiments upon dogs. The chief objection to it is that it leaves the edges of the wound in an uneven, puckered condition, which interferes, perhaps, somewhat with rapid union. This, however, may be prevented in great degree, if not wholly, by the employment of a double thread, after the fashion of the glover, although I do not consider this at all essential to success. Of the seventeen experiments performed with a single ligature, not one terminated fatally. The wounds in two of the cases were transverse, oblique in three, and longitudinal in twelve. The wound in one of the latter was six inches in length The dog, a large, old one, was killed on the twentieth day, when every trace of suture had disappeared, with the full restoration of the calibre of the tube. I must not omit to state that in all these experiments the sutures were passed through the fibrous tunic of the bowel, or, in other words, outside the mucous membrane. We have here, tnen, also a very valuable suture for sewing up wounds of the intestines, especially well adapted to the treatment of longitudinal and oblique wounds; not so well, I think, to the treatment of transverse ones as the interrupted.

The suturing of the wound having been completed, and any foreign substance that may be present removed, the bowel is restored to its natural situation, followed by the omentum, in the event of its prolapse. It is hardly necessary to say that the protruded structures should be treated in the most gentle manner; any wiping that may be required should be performed with the softest cloth, and all firmly adherent matter should be picked off with the forceps. Generally speaking, the best way of cleaning the parts is to make free use of the syringe, charged with warm water. The operation may be completed with a one to one thousand solution of corrosive sublimate. The return of the bowel will be materially facilitated by the use of a little olive oil. If any serious obstacle offer, it must be surmounted with the probe-pointed bistoury, or by puncture of the tube, if it depend upon the presence of gas. The wound in the wall of the abdomen should be closed in the same manner as in ovariotomy, the sutures being carried through the peritoneum so as to protect the parts effectually against hernial protrusion, a thing never to be lost sight of after such lesions.

The question arises here, What should be the conduct of the surgeon when the bowel is wounded, but not prolapsed, owing to the small size of the mural opening? I do not think I can answer this question better to-day than I did forty years ago, when we knew comparatively little of abdominal surgery, and when the most visionary enthusiast could not have dreamed of half the triumphs that have since awaited it. The case in question is a suppositious one, and is thus stated: "A man, after having indulged in a hearty repast, receives a penetrating wound in the abdomen from the thrust of a dirk or knife; the bowel is pierced, or it may be, nearly divided, and there is a copious discharge of fecal matter, both externally and into the peritoneal cavity, as is evinced in the latter event by the excruciating pain, the gastric oppression, and the collapsed condition of the sufferer. Here the most prompt and decisive measures must be resorted to, or the person will perish from peritoneal inflammation, with as much certainty as if his skull had been fractured and a portion of his brain had been let out. It will not do for the surgeon to fold his arms, and look upon the scene as an idle and disinterested spectator. Far otherwise; he has a duty to perform, and that duty consists in dilating the external wound, if it be not already sufficiently large, in hooking up the injured bowel, and in closing the solution of continuity with the requisite number of stitches, at the same time that the effused matter is carefully removed with tepid water and a soft sponge. All wiping must, of course, be carefully avoided, as this would add much to the risk of peritonitis.

It is a rule with all educated surgeons to do the work which they are called upon to perform in as complete and thorough a manner as possible, and nowhere is this precept of greater importance than in the treatment of wounds of the intestines. A case recently reported by Professor O. K. Roberts, of Louisville, Ky., will aid me in illustrating my meaning. A man was cut in the abdomen with a pocket-knife; the wound was three inches long; the bowel protruded, and was pierced at two points, one opening being of the size of a common lead-pencil, the other of a pea. The knife in its passage had stripped off the serous membrane over a space of one inch by one quarter. There were two slits in the mesentery, each one inch in length; and the patient had lost much blood. The mural wound was closed by sutures which embraced only the skin and superficial fascia. None of the bleeding vessels had been secured, and active bleeding was still going on from three points in one of the wounds in the mesentry, the other being occupied by a clot. It was in this condition that the man was found by Dr. Roberts, shortly after his wounds had been dressed by another surgeon. Satisfied at a glance that the case had not been properly managed, Dr. Roberts reopened the mural wound, secured the bleeding vessel with carbolized catgut ligatures, stitched the opening in the gut more thoroughly, washed out the peritoneal cavity with hot carbolized water, and closed the abdominal wound with deep sutures, completing the dressing by inserting a drainage-tube in the lower angle of

the wound. Under this treatment, with proper subsequent care, the man made a rapid recovery. Had the dressing originally applied been allowed to remain, death would have been inevitable; either from hemorrhage, peritonitis, or peritonitis and septicæmia. The case affords a happy exemplification of hasty, careless, slovenly surgery, on the one hand, and of thoughtful, wide-awake, scientific surgery on the other.

The therapeutics after all such lesions is sufficiently simple. The great point is to prevent peritonitis, or to combat it, if it takes place. The posture should be such as to relax thoroughly the abdominal muscles. The bowels should be locked up with opium, to prevent peristaltic action, and nothing but iced water or pounded ice, aided, if there be much gastic distress, by a small allowance of dry champagne, should be permitted during the first three or four days. Oppression from gas should be relieved with injections of turpentine and asafœtida. Peritonitis should be met with leeching, followed by vesication with cantharidal collodion, and full doses of opium; venesection will be proper when the patient is young and robust. A laxative of castor oil, or of sulphate of magnesium, may be given at the end of five or six days, if there be marked suffering from tympanites. The urine should be drawn off during the first few days, with the catheter.

I have, thus far, said nothing of gunshot wounds of the intestines. Such wounds are generally of a very serious nature, and are, therefore, liable to be followed by the worst consequences. In the first place, they are nearly always concealed wounds, from the fact that there is no prolapse of the bowel; secondly, such wounds are commonly multiple, as in one of my own cases, in which there were as many as eight perforations—two in the ileum, two in the jejunum, two in the duodenum, and two in the arch of the colon; thirdly, there is always more or less copious effusion of fecal matter; fourthly, great shock, to say nothing of hemorrhage, which nearly always attends; and, lastly, most patients who survive the more immediate effects of such injuries are almost certain to succumb to peritonitis. The only rational treatment in such cases is to expose at once, or with the least possible delay, the peritoneal cavity, to stitch up, or excise, the wounded bowel, and, lastly, to clear away all extraneous matter. Excision of the tube is imperatively demanded when the wound is very large, severely contused, or very ragged. Nothing short of this would answer under such desperate circumstances; and even then no sensible surgeon would venture to pronounce a favourable prognosis.—*Med. News.*

PROF. PARVIN favors the employment of anæsthetics during the use of the forceps.

INFANT DIGESTION.

In the July number of the "Archives of Pædiatrics," Dr. H. R. Bigelow, of Washington, says: "The question of infant growth is one of assimilation. Assimilation of food will depend upon the integrity of the digestive function. The digestive system of the new-born is not formulated at once, but developes in logical ratio with the expansion of other parts of the body. Its measure is the requirement necessitated by the elaboration of tissue. Tissue-growth is a slow process, demanding special nourishment, and varied at each advance in age. The necessities of the child, both chemical and physiological, are not those of the adult, because each is adjusted with great exactness to the immediate environment. The excess of non-nitrogenous matter, which is an essential to adult life, is pernicious to the well-being of the infant. Muscles, when at work, consume principally hydrocarbonaceous aliments, and not albumenoid substances. In the infant there is no muscular exertion, and hence it draws more largely for its developement upon the nitrogenous substances than upon the hydrocarbons. At birth the alimentry tract is short, the cæcum being very small and the masticatory organs are absent. Bidder says that the ptyalin appears only with the cutting of the first tooth. Reasoning from analogy, it is not improbable that the pancreatic and intestinal ferments are also inoperative until about the eighth month. Nature is not a spendthrift, and she would not call into useless action any function not demanded by the necessities of her own handicraft. With the eruption of the teeth a new era begins. Mastication presupposes increased development. Increase of development calls for increase of nourishment, and increase with variety in nourishment sets up new digestive processes, in which the ptyalin and other ferments play an important part.

"The alimentry tract of the infant is exceedingly susceptible, so the nursing women have to be very careful in their diet. Now, if this tract is so impressionable as to feel any departure from a standard diet in the mother, how much more seriously will it suffer in the administration directly of unwholesome cow's milk—not unwholesome, perhaps, in the light of general use, but unwholesome for the limited infantile digestion. It may have an *acid* reaction, or it may have come from a cow in *heat*, or it may be tainted with certain vegetable substances obnoxious to the child. The natural food of the baby is its mother's milk.

"An intelligent study of human milk will lead up to a more just comprehension of the demands of infant digestion, and to a more perfect knowledge of a physician's duty in prescribing for such cases as are, unfortunately, deprived of the mother's breast. It would be a valueless encumbering of space, and an expenditure of time without profit,

to cite one half the analyses that are matters of record. It best subserves the present purpose to view the main constituents of human milk in their relation to certain physiological principles. It is to be noticed first, that woman's milk has an *alkaline* reaction, which persists for an indefinite period, and a specific gravity of about 1.0317. It contains water largely in excess(89.20 in 100 parts) milk-sugar, nitrogenous matter, fat, and salines. The albumenoids will vary in different women so largely that we can not affirm that any analysis is infallible. A fair average percentage would probably be about 4.84. The milk-sugar (6.987) is much greater than in cow's milk (4.92). These figures are only approximately correct. No two samples yield the same results. This variability in the composition of women's milk, if not pathological, is a wise dispensation of nature to provide for the exigencies of each month of advancing age. Thus the function of the milk-sugar as a heat-producer is kept constantly in mind, while the absolute rate of nutrition may vary within wide limits, because the bodily heat must be preserved at all hazard. In fat, women's milk exceeds that of the cow, but falls far below it in albumenoids. The ash, or mineral constitutent of milk, is chiefly concerned in metamorphosis. The basic phosphate of sodium is invariably found in the blood while the acid phosphate of potash is the chief constituent of the juice of the flesh, Phosphate of lime is intimately incorporated with the nitrogenous constituent principles. It is very generally admitted that the carbohydrates lead on to fat-production, through the co-operation of the nitrogenous and saline elements. Nitrogenous elements themselves, when in excess, may also serve as a source of fat. Nitrogenous matters do not, probably, undergo complete oxidation within the body ; a portion of them is eliminated as urea. Fatty compounds are of higher value as force-producers, because they contain a quantity of hydrogen as well as of carbon free of oxidation. Pavy says that the value of nitrogenous compounds as force-producers depends upon the amount of unoxidized oxidizable elementary matter they contain. In human milk the percentage of nitrogenous matter to carbohydrates is about 1.45. About one fourth part of its casein is coagulable by acid. The *alkaline reaction* is *highly valuable*, since it serves to convert the *casein* into *soluble albumenoids* and soluble carbohydrates, which are great heat-producers. Writing upon this subject, Kuss says: 'It is generally admitted (Moleschott, Voit) that an adult consumes 320 grammes of carbon and 21 grammes of nitrogen, or in other words, 130 grammes of albumenoid elements, and 488 grammes of hydrocarbons and fats (fats 84, hydrocarbons 404) ; it follows that, in this case, the normal proportion in a mixed diet, of nitrogenous to non-nitrogenous aliments, is 1 to 3.7, while in milk, as well as in the egg, the proportion is 1 to 3, or even 1 to 2 ; in other words, the quantity of albumenates (nitrogen) is much larger, and of hydrocarbons (carbon) much smaller. This fact may be easily explained by referring to the part played by the hydrocarbons in regard to the production of force—muscular force especially. The adult draws his forces from the combustion of non-nitrogenous substances, the albumenates scarcely serving for this purpose. On the other hand, when the organism is in course of development, the nitrogenous substances are indispensable to the growth of the different tissues. It is therefore easy to see how mistaken is the common practice of condemning children to a diet containing a large quantity of starch and scarcely any nitrogen.'

"Women's milk contains no *starch*. It may be conceded that, in the adult, the ptyalin may continue its action in the stomach ; that particles of unconverted starch may be transformed by the pancreatic and intestinal juices. In the infant this rule cannot apply. The baby does not secrete ptyalin until the sixth or eighth month, *neither do the other juices, of pancreas and intestine, have any transforming power whatever before that period.* It is sheer ignorance to assert small particles of starch can do no harm, since they undergo transformation in the intestine, when the truth is that they not only act as irritants, but pass out of the bowels unchanged. The attenuant of woman's milk is an important factor, of which we have little absolute kowledge. It is chiefly in consideration of this point that *cow's milk can not ever be safely substituted for that of the mother.* Before it can be satisfactorily approximated to this great food of nature it must be radically transformed by some chemical process, which science has not yet developed. The addition of water to cow's milk will reduce the percentage of albumenoids into harmonious relationship with human milk, but it does not suffice to change the characteristics of the clot. To use starch as an attenuant is, of course, radically wrong.

"In view of these facts, it becomes a matter of the utmost interest to establish some definite principles of treatment, in cases where the mother is unable for any reason to nourish her child properly and sufficiently. There is no known process, chemical or mechanical, by which cow's milk alone can subserve this purpose. Up to six months of age, at least, the baby needs just those equivalents found within the mother's breasts—nothing more and nothing less. The compound must be *alkaline* in reaction ; it must contain no *cane sugar* (because cane-sugar must be first converted into grape-sugar before it can be assimilated ; cane-sugar is frequently subjected to a kind of acetous fermentation, producing excess of acids in the infant stomach so that bodily heat will diminish and disorders of respiration and circulation will follow), and no *starch*. It must be rich in heat-producers, although, as I have said before, the amount of albumenoids

may vary greatly. Position has something to do with digestion. In some bad cases it will be found that, if the infant be placed in the usual position of a nursing child in its mother's arms, it will assimilate its food, when artificially fed, much more readily. In the nursing child a by no means inconsiderable amount of heat is derived from the mother's body. An artificially fed infant is deprived of this, so that there should be some compensatory action in its food. There have been many attempts made to overcome this difficulty, and our journals have been full of discussions upon the matter. It may be said that no artificially prepared food that does not meet in all these requirements will be of permanent value in infantile therapeutics. What is needed is something rich in carbohydrates, with a proper admixture of albuminoids, salts, and moisture, free from starch and alkaline in reaction."

Dr. Bigelow gives notes of three cases of disease in infants, with disturbed digestion or assimilation, in which great benefit attended the use of Mellin's food. "I satisfied myself," he says, "by personal analysis of the constituents of the preparation, and found that it contained the principles which it seemed to me nature demanded, in exact combination, and more satisfactorily and more cheaply prepared than I could compound upon my own prescription."

EPILEPSY TREATED WITH HYDROBROMATE OF CONIA.

BY R. NORRIS WOLFENDEN, B.A., M.B. CANTAB.

Being frequently disappointed in the action of potassium bromide in the treatment of epilepsy, I have lately been trying a remedy which I believe has not previously been used for this complaint. If the result is not quite so favorable as I might have expected, it is at any rate sufficiently good to warrant further trial, and I venture to place on record the notes of seven cases, in the hope that it may lead to further observations. We have all experienced the failure of potassium bromide until poured in in such quantity that often a condition of bromism is established. The unsightly blotches thus produced are a source of annoyance, especially to the better class of patients, to whom personal appearance is a matter of concern. The following is a summary of my notes.

CASE 1. A., girl, æt. eight: ill for two years, with epileptiform seizures consisting of sudden flexions of the fore-arm (right), and a momentary vacantness of look; latterly the attacks had become more severe, culminating in loss of consciousness. Hydrobromate of conia. in doses of half a grain three times a day, was prescribed. During the first week she had six slight "fits." The dose was then increased to 5/8 of a grain, and during the succeeding week she had no attack. The medicine was continued for four weeks, during which time she had no fits at all, and slept better. The drug was then discontinued for some weeks, when she returned for further treatment. During its administration this patient complained of constant frontal headache.

CASE 2. B., male, æt. 22: suffered from true epileptic fits, with typical aura, convulsions, unconsciousness, and great headache afterwards. One and a half grains hydrobromate of conia was ordered twice a day; during the week, this patient had nine fits. One and five-eighths grains was given twice daily for a week. During this time the patient had four bad fits. He was now, at his own request, put under potassium bromide, ʒ j doses, three times a day, which kept them under.

CASE 3. C., female, æt. 34: had been ill for four years, with one or more fits every week, typically epileptic. While taking potassium bromide they were kept under. I ordered one grain of hydrobromate of conia twice a day to commence with. For a week she was better, with only one slight attack. The dose was increased to 1½ grains, and during the next fortnight she had one slight fit. She was then ordered back to bromide.

CASE 4. D., girl, æt. 7: has seven or eight fits a week, of a typical epileptic character. She has frequently right-sided convulsions, the right arm being suddenly flexed. Sometimes these culminate in a real fit, with insensibility and rigidity. The child is an imbecile. As while under ʒ j doses of bromide, the child still had frequent fits, I ordered ½ grain of hydrobromate of conia three times a day. For the first week she had five fits (all occurring the day after the medicine was changed). For the second week there were seven fits. The drug was increased to ½ grain three times daily. For a fortnight she was absolutely free from fits, and then had seven. The drug was continued for some weeks, but she still had fits occurring at irregular intervals, which were refractory both to conia and potassium bromide.

CASE 5. E., female, æt. 27: has typical epileptic fits which continue under ʒ j doses of potassium bromide. I administered ½ grain of hydrobromate of conia three times a day. During the next week she had no fits and stated that she felt better, but with frequent headache. For a month while under this treatment she had no fit, but complained of more frequent headache, in consequence of which I returned to bromide.

CASE 6. F., male æt. 18: would have three fits a day, and then go for a week without. They were typically epileptic fits. While under large doses of bromide they were kept under, but not untill an unsightly bromide rash was established, which was troublesome to the patient. For the first week, while taking one grain hydrobromate of conia twice daily,

he had three fits. For a fortnight longer while under this treatment he had two fits. During the whole three weeks he therefore had five typical epileptic fits. As he stated that the drug made him feel giddy and weak, I returned at his own request to bromide, which so long as he was entirely under its influence in large doses seemed to ward off his attack. This young man was of weak intellect.

CASE 7. G., female, æt. 15 : suffered from true epilepsy, dilated pupils; her optic discs were congested. She had not menstruated and had phthisical symptoms (cough, hæmoptysis, sweating). Half-grain doses of hydrobromate of conia were ordered three times a day. During three weeks she had no fit, which she stated was the longest time she had ever been without. I then lost sight of her.

The conclusions I draw from the treatment of these seven cases are—that the drug is undoubtedly serviceable in certain cases, and those in which it fails are cases of convulsions depending possibly on some gross lesion of the brain (Cases 4 and 6). The slighter cases (*e. g.* Cases 1 and 7) were distinctly benefitted by it.

The drawbacks to the use of the drug appear in the complaints of headache, and where in large doses, of giddiness lasting for an hour after taking it, with sometimes a suffusion and congestion of the conjunctivæ. In the doses in which I have given it, there has not been noticed any cardiac or respiratory alteration. It is said that the dose of this drug must not exceed 4½ grains in 24 hours, commencing with 1½ grains. In my experience a child of eight bore 1⅞ grains with only headache; a child of 7 took 1½ grains per diem, without any complaint: 2½ grains per diem, were taken by a female without complaint: one adult man took 3¼ grains with impunity. In one case two grains per diem caused sickness, headache, giddiness, and "weakness" in a man of 18. One and a half to two grains appears to be followed frequently by headache. I think the drug deserves further trial. Combined with constant application of the continuous current, I have successfully treated with it a case of hemichorea. In this disease however, it would be rash to speculate whether the drug, the galvanism, or the time was the most effectual in the cure.—*Practitioner*, June.

THE TREATMENT OF DIABETES MELLITUS.

In the *Col. and Clin. Record* Aug. 84. Dr. Flint Jr. gives the following summary of treatment. He says:—"The more I study the cases of diabetes that have come under my observation, especially those that are now under treatment, in connection with the writings of those who have faithfully followed the dietetic plan, notably Bouchardat and Cantani, the more thoroughly I am convinced that the prognosis in a recent and uncomplicated case of this disease in an adult is invariably favorable, provided, always, that the proper measures of treatment be rigidly enforced. In the hope of convincing the profession that this statement is reliable, I shall at the risk of what may appear to be needless repetition, give a summary of treatment, with brief statements of the progress of cases that I am now actually observing.

At the outset, patients should be impressed with the fact that they are suffering from a grave disorder, and that everything depends upon their full co-operation in the treatment, which treatment is essentially dietetic. The diet table should be carefully studied, and the diet regulated and carried out absolutely. In case a rigid anti-diabetic diet does not promptly influence the glycosuria, it may be well to subject the patient to an absolute fast for twenty-four hours and follow this with anti-diabetic regimen. This rather harsh measure is suggested by Cantani. I shall not hesitate to employ it in cases in which it may seem to be required, although no such case has yet come under my observation. Systematic daily muscular exercise should be enforced. A moderate system of training on the plan adopted by athletes is most useful; and this, if continued, will do much to render a a cure permanent after a return to the normal diet.

The return to a normal diet should be gradual, and during this time the urine should be frequently examined, the rigid diet being resumed at the first reappearance of sugar in the urine; but all alcoholic excesses, the immoderate use of sweet fruits, and any use of sugar, should be interdicted at all times. A patient who has once had diabetes is always liable to a return of the disorder. He must lead a thoroughly careful, hygienic, and temperate life. In the words of Bouchardat, "you will not be cured except on the condition that you never believe yourself to be cured."

While I believe that the physician is justified in encouraging patients to expect relief, and even cure in recent, uncomplicated cases, the diet is all important, and its regulation cannot be expected to be perfect without professional aid in its enforcement. A diabetic is never safe from a return of his disease, even when he believes himself to be cured; and under no circumstances should he pass more than a few weeks without an examination of the urine.

The arsenite of bromide, or Clemen's solution, appears to be useful. It consists of arsenious acid and bromine dissolved in water and glycerine in such manner that two drops represent the 24th. part of a grain of arsenite of bromine. We may begin with 3 drops three times daily in a little water immediately after eating, gradually increasing the dose to 5 drops. This may be continued for weeks and months without producing any unfavor-

able effects; but the administration of this remedy does not supply the place of the dietectic treatment, which should be enforced in all cases. Cantani recommends lactic acid "lemonade" 1 to 2 drachms to the pint of water and flavored A rigid diet should be continued for two months, at least, even in the mildest cases of the disease. It may be necessary, in certain cases, to continue it for a longer period, even twelve or more months. There is probably no such disease as intermittent diabetes. In some instances glycosuria occurs during the season of sweet fruits, when they are indulged in excessively, and disappears when the diet is changed; but these are mild cases of diabetes, excluding those in which a transient glycosuria follows the inhalation of irritating vapors, the taking of anæsthetics, etc. Robust or corpulent persons are more tolerant of the disease than those who are feeble or spare, and the glycosuria yields, in such cases, more readily to treatment.

Diabetes occurs at all ages. Bouchardat mentions a case in an infant of 3 years, although the disease is rare before the age of 12. The most unfavorable cases are those which occur before the age of puberty. An adult male presents the most favorable conditions for cure. In old persons, when the disease is of long standing, the dietetic treatment will secure practical immunity from nearly all the distressing symptoms, although the glycosuria may not be entirely removed. A study of any of the diet-papers recommended will make it evident that those who are able to follow the required regimen, without regard to the cost of articles of food, present much more favorable conditions, as regards the prospect of cure, than persons in straightened or indigent circumstances. Diabetes, however, occurs in all classes, and is by no means a rare disease. A hospital devoted to such cases, where the dietetic treatment could be strictly carried out, would be a boon to the rich and poor alike."

ANEURISM CURED BY DIGITAL COMPRESSION IN SIX HOURS AND A QUARTER.

In the *Brit. Med. Journal*, Arthur E. J. Baker, F.R.C.S., Eng., of University College, reports the following interesting case:

J. D., aged 36, was admitted into University College Hospital, under my care, on August 29th, 1883, suffering from an aneurism of the right popliteal artery. For this he had been already carefully treated, by M. Gandy, of Norwood, with a Skey's tourniquet, applied almost continuously for five weeks. This compression had had no effect upon the tumour. The patient was a particularly healthy, fresh-looking, cheerful man, whose personal and family-history were excellent, and showed no evidence of constitutional disease of any kind. He had always been a gardener, working for the last eleven years in a very hilly garden, and doing all the work (which was very heavy) himself. This overstrain appears to have been the only exciting cause for the aneurism in this case. The appearance of the tumour dated from eight weeks before admission, when he first noticed pulsation in the ham. He was unaware of any special strain or other cause for it, and it gave him at the time no pain. Its size had remained the same since first observed. On admission, the swelling was of flattened oval shape, about two inches in diameter; it was tense and elastic, and pulsated strongly. It was seated exactly opposite the middle of the knee-joint, and was slightly red on the surface, having a distended vein on its outer side. There was aching pain on flexing the leg, but none when the limb was at rest in extension; some tenderness on pressure on the tumour was complained of, but none in the thigh or leg. Pressure on the superficial femoral artery arrested all pulsation in the sac.

Instrumental compression having failed, and the man being extremely anxious that something radical should be done, I ligatured the superficial femoral artery in Scarpa's triangle on September 6th, 1883. The operation was done in the usual way under spray, and the vessel was tied with a twisted silk ligature well carbolised, which was cut short and left in the wound. The first ligature broke in drawing the second half of the knot; the next piece of silk bore the strain well, and was placed a quarter of an inch above the first spot chosen. The pulsation in the aneurism was now found to be completely controlled, and no pulsation was felt in it until about five hours later, when it was just perceptible. The tumour gradually shrank, while over it a small artery could be easily felt. The wound healed, without any trouble of any kind, by first intention throughout, the ligature showing no signs of coming away. The patient left hospital on October 1st, looking and feeling very well. At this time there was no pulsation to be felt in the tibial arteries, and no discomfort or pain anywhere. In this condition the patient remained at home until the second week in January, 1884, (about four months). He then noticed a return of pulsation in the right popliteal space, with pain in the knee as this gradually increased. A week later he came up to see me, when I found the aneurism almost, if not quite, as large as before the ligature of the femoral artery, although the latter, below the seat of ligation, was now pulseless, as were also the tibials. Above the ligature the vessel pulsated strongly. Pressure on the common femoral, below Poupart's ligament, completely controlled the expansile stroke in the aneurism, and from this there could be no doubt that it was fed by branches of the profunda, which had been

presumably enlarged during the five weeks of instrumental compression of the common femoral, which had preceded ligature. Of course here there could be no question of the ligature having dissolved away, as it was of strong silk, and the vessel was still pulseless below its seat; moreover, pressure on the femoral at this spot did not affect the aneurism, whereas pressure above the pro funda did so at once.

I now determined to try digital compression, and, on the readmission of the patient on January 26th, he was put upon a somewhat restricted diet for two days, being confined to bed, and smartly purged. The effect of this treatment in lowering the arterial tension was most marked, and to it, no doubt, some of the good result may be attributed. Then, on the 28th, having a number of most willing volunteers from among the students, I commenced digital pressure of the common femoral at 10:50 A.M. This was carried out with the same attention to details referred to in my former case, and, at 5.15 P.M., all pulsation in the aneurism had ceased finally. Compression was still continued until 8 P.M., and then stopped. The temperature of the limb remained lower than the other for some time, but all discomfort and pain was soon gone. The patient returned home cured on February 5th. Since then, I have seen him several times; there has been no return of the aneurysm, which has shrunken up to small size. The pulsation in the tibials is still absent. The man is now engaged in his gardening work as before, without any ain or trouble from his former ailment.

EARLY SYMPTOMS OF CANCER—HUTCHINSON.

As Emeritus Professor, Professor of Clinical Surgery Mr. Hutchinson is now delivering his second annual course of lectures at the London Hospital. This course was instituted last year on the occasion of Mr. Hutchinson's retirement from the acting surgical staff, when he was appointed consulting surgeon. It was considered desirable to retain him as a teacher in connection with the Medical College, so he was made Emeritus Professor, and undertook to deliver six lectures annually on some subject connected with surgery.

The lectures for the present year are perhaps a greater success than those given last summer, and being wholly delivered extempore appeal more directly to the minds of the auditors. It goes without saying that Mr. Hutchinson gives no mere summary of ordinary text-book opinions, but lays before his hearers, in plain and unmistakable terms, the results of his own clinical experience.

On Wednesday, July 2nd, a good audience assembled to hear the lecture on "The Early Recognition of Cancer." The term "cancer" was used in its clinical sense and as including sarcoma, and not in its limited anatomical sense applying solely to carcinomatous growths. The importance of its early recognition was obvious. Mr. Hutchinson said that before the actual presence of cancer was what might be termed the pre cancerous stage, and this was essentially a condition manifested by signs of local inflammation. An interesting case was narrated in support of this view. It was that of an old gentleman whom Mr. Hutchinson saw in consultation some years ago. One testicle had enlarged and was slowly increasing in size. The surgeons who saw the case agreed that it was probably not malignant and recommended non-interference. It continued to grow, however, and was at last removed solely by request of the patient, who had all along been anxious about it lest it should be cancerous. It was examined microscopically and was found to be simply in a condition of inflammatory hyperplasia, and no signs whatever of malignancy were discoverable. The patient recovered from the operation, no further trouble manifested itself, and his medical attendants came to the conclusion that his testicle had been unnecessarily removed. Two years elapsed. The remaining testicle then began to enlarge in the same way in which the other had done. Remembering the result of the previous operation, the surgeons strongly advised the patient against operation. As before, it continued to enlarge until finally it reached a considerable size. At last even the surgeon began to be alarmed and the patients anxiety was extreme. The testicle was at last removed at the urgent request of the patient. It was examined and proved to contain a well marked sarcomatous growth. The inference was that the one first removed would, if allowed to remain, have also acquired a sarcomatous structure, and that the inflammatory hyperplasia found was a condition leading up to that of actual malignancy.

Eczema of the nipple preceding cancer was an illustration. Mr. Hutchinson remarked that cancer attacked parts that were functionally dead. as the breast in women late in life. Among animals it attacked the cat, the dog, and the horse, but not the sheep. The two former animals led a lazy life and were allowed to drag out their existence to old age. Sheep were usually killed before they were old enough to develope cancer.

The practical conclusion Mr. Hutchinson drew from his view was to treat as cancer all those cases where you suspected it—to adopt active measures at once and not wait for more decided symptoms until it might be too late.—*Med. Record.*

Oliver Wendell Holmes says that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

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MEDICAL SCHOOL OPENINGS.

The first of October is generally considered a red-letter day among medical students and professors in medical colleges in Canada and Europe. In many medical colleges both at home and abroad, it is customary to begin the work of the session with an introductory lecture on some general or special topic. In some the practice has been discontinued, and in others revived after a period of suspense. The beginning of the present session has been no exception to the general rule. Our exchanges bring us brief reports of the medical school openings in the mother-land, and the festivities which accompanied them in the form of hospital dinners and conversaziones. Some of these were on a grand scale of magnificence, and were the means of bringing together in friendly intercourse, old class-mates, fellow students, and professors. St. Bartholomew's, Guy's, St. Thomas', St. Mary's, King's, London, etc., vied with each other in the character and success of their respective festivities, and the friends and patrons of each turned out in force to do honor to the occasion. Although in Canada we have not yet inaugurated the festive part of the programme, we have not lagged behind in the "feast of reason." The introductory lecture is now a constant feature in all the medical schools in Canada, and in its general scope and character will compare favorably with those of a similar character in older and more favored countries.

The introductory lecture of the course in Trinity Medical College, Toronto, was delivered by Prof. Geikie, Dean of the Faculty. After welcoming the assembled class, he referred to the large graduating class of last year and the honor they had done the school and themselves by their successful examinations at home and abroad. Their example was held up as a model, and a like success was confidently predicted for all who would bring diligence and perseverance to bear upon their studies. The lecturer chose as his main subject, the history of the origin of medicine amongst the Egyptians, Jews, Greeks, and Romans, passing down through the centuries to our own times. He dwelt upon many medical superstitions, especially those connected with amulets and charms. He closed with a strong appeal to those present to prosecute their studies with that zeal and thoroughness which alone would lead to distinction during their college career, and throughout their entire subsequent professional life. He also earnestly cautioned them against giving way to any temptations to idleness or vice. They were urged to be very careful in the choice of their companions, and especially to steer clear of any who have the misfortune to rank amongst either the idle or the vicious.

At the Toronto School of Medicine the opening lecture was delivered by Dr. George Wright, who, after welcoming the students and referring to the success of the school, gave some timely advice to those about to enter the profession. He alluded to the interesting character of the study of medicine to the enquiring mind. The whole domain of nature, animate and inanimate, came under their observation in some way or other. They were now laying the foundation in professional work which was either to make or mar their success through life. He was a firm believer in the doctrine that each one had special adaptabilities, and the more accurately these could be gauged the more likely would be the success. He cautioned them against the tendency to be content with purely theoretical knowledge, and advised them to utilize all the advantages within their reach for the practical study of disease in all its varied phases. He deprecated any slipshod preparation in so important a profession and condemned the three years' course system. Brief addresses were also delivered by Drs. Workman, Thorburn and Richardson.

The opening lecture of the Royal College of

Physicians and Surgeons, Kingston, was delivered by Dr. Fife Fowler, Dean of the Faculty. He referred to the many successful students who had been educated in the College and who now occupy positions of honor and usefulness. Genius, accompanied by energy and application, could accomplish wonderful results; but the careful, plodding, persevering student often in the end succeeded in obtaining what the restless, fitful men of talent failed in accomplishing. He then referred to the motives which impel men in the race of life: that while some are urged on by envy, the love of success, or the love of money, the highest motive was the knowing and the doing of one's duty. Life should be viewed with exalted and purified minds, and the moral nature should be matured and elevated. The necessity of bed-side observation was strongly emphasized. The importance of being honest in thought, word, and deed, and the usefulness of acquiring business habits was referred to. He also dwelt on the importance of having such moral qualities as decision, courage, self-reliance, and individuality, and although their paths would not all be paved with daisies, he advised them to be of good cheer and arm themselves with prudence, fortitude and truth.

At the opening of the medical department of the Western University, London, Dr. J. M. Fraser delivered the introductory lecture. He referred to the good conduct and success of the students of the classes in previous years, and to the gratifying results of their efforts in the local examinations as well as at those of the Ontario Medical Council. He next referred to the responsibilities the medical student assumed on entering the profession, whose aims were to alleviate human suffering and prolong life. The responsibilities at the bedside of the sick and the suffering were of the gravest description, and required the highest cultivation and preparation, nicety of perception, calmness of judgment and an utter avoidance of self-seeking propensities or arrogance. He pointed out many of the solemn and sacred duties which the physician owes to his patient, or to the families of those with whom he comes in professional relation, and showed how necessary on his part was the exercise of kindness and sympathy. He pointed out the high aims before the student of medicine, noted the difficulties and obstacles to be overcome, indicated the vastness of the fields of medical science as yet unexplored or only partially understood, and expressed the hope that among those who, in the future, will be eminent in the profession and benefactors of the race, might be graduates of the Western University.

The opening lecture of McGill Medical College, Montreal, was delivered by Dr. Penhallow, Prof. of Botany in the University. The subject treated upon was "the relative position which the teaching of botany holds in the various schools in this country and the United States." The lecturer dealt with the question in an able and comprehensive manner, and was listened to with marked attention. Space does not permit our giving a digest. The prospects of the school for the present session are good, upwards of seventy new students having registered up to the 15th ult.

Up to the time of writing we have had no official reports from Bishop's Medical College, Montreal, or the Winnipeg Medical College, but have learned indirectly that their prospects for the present session are very good, the attendance being greater than last year.

The opening of the Women's Medical College here and in Kingston also took place on the 1st ult. The following extract from the address delivered by Dr. Alice McGillivray, at Kingston, may be taken as representing the sentiments of those who favor women entering the arena of medicine: Ladies, whatever your motive in undertaking this serious responsibility, whether it be from a desire to earn a livelihood or to provide against future contingencies, or from a realization of the many existent ills among those of our own sex, who shrink from seeking relief elsewhere, or in response to the appeal from the multitude of our suffering sisters in India, who are permitted to die unattended, we know each one of you will strive to achieve a high place as a student, to preserve all good grace becoming a lady, and in future to distinguish yourselves as much by your womanly dignity of character and goodness of heart as by your skill in the profession.

The number of those entering the profession seems to be ever on the increase. This year especially there would appear to be a much greater number than in previous years. McGill College, as before stated, has upwards of 70 freshmen. In the Kingston School the freshman class is larger than usual. The Toronto School of Medicine has

a goodly number. The number of freshmen in Trinity Medical School this session mounts above 100, the entire class numbering about 250. Abernethy's exclamation may well be reiterated: God bless you, gentlemen! What is to become of you all!

THE QUEBEC LUNATIC ASYLUMS.

Grave complaints have been made from time to time for several years past by well-informed persons regarding the management or rather mismanagement of the asylums in the sister Province of Quebec. Dr. Hack Tuke, the well known alienist, who accompanied the British Association to Canada, availed himself of the opportunity to visit the asylums in Ontario and Quebec. The report of his visits to the Quebec Asylums was forwarded to the Hon. the Provincial Secretary, and has been made public. It is in truth a formidable indictment of the general management and moral treatment of the unfortunate insane in that Province. In regard to the cleanliness and order in the principal parts of the asylums there is much to commend; but in the upper storys and the refractory wards he finds "a skeleton in every closet." The wards are poorly lighted and ventilated, and almost destitute of any provision for the comfort of the inmates. One ward in the Longue Point Asylum, Montreal, he characterizes as a "chamber of horrors." In the corresponding portion of the building on the female side matters were no better—"a veritable pandemonium." Many were restrained by various mechanical appliances—muffs, manacles and straps—who should have been governed by moral restraint alone. They were closely huddled together and the atmosphere was stifling in the extreme. In the fourth story were the idiots and imbeciles, removed from all humanizing influence, treatment or education. The condition of the patients confined in the gallery, roof and basement, was beyond adequate description. In contrasting the condition of the asylums in Quebec with those in Ontario he says:—"The astonishment which I experienced in witnessing this relic of barbarism in the Province of Quebec is still further increased when I see such excellent institutions as the lunatic asylums of the adjoining Province of Ontario. I am certain that if it were possible to transfer the worst patients now in the asylum at Montreal to these institutions, they would be freed from their galling fetters and restraint chains. They would quit their cells also, and, in very many instances, be usefully occupied where they are now restrained, with the result that in not a few cases perfect recovery to health would follow. 'Look on this picture and on that,' were words constantly in my mind after visiting the institntions of the two Provinces."

In discussing the cause of this lamentable state of affairs, he says, it is due entirely to the contract or farming system. This, it cannot be too often repeated, is the essential root of the evil, and unless speedily abolished will bear bitter fruit. In the conclusion of his report Dr. Tuke advises the Government to undertake the responsibility of providing the necessary accommodation and treatment of the insane poor, appoint resident medical superintendents with full authority, a competent board of management and efficient inspectors, and then the asylums would become institutions of which they would be proud instead of institutions of which they are now heartily ashamed.

ANOTHER MALPRACTICE SUIT.

At the recent assizes in this city an action was brought by a patient named McClure against Dr. Grant, of Woodbridge. The plaintiff had the misfortune to receive a severe fracture of the leg from a kick in a drunken brawl. Dr. Grant was called in and treated the fracture by means of a fracture box, first applying a bandage to the limb. About the ninth day dry gangrene began to appear in the great toe. Dr. Stevenson, of Kleinburg, was called in consultation, and both he and Dr. Grant examined the bandage and came to the conclusion that whatever might be the cause of the gangrene, it was not due to the bandage. On the following day, Dr. Savage, of Thistleton, visited the patient in the absence of Dr. Grant, removed the bandage, and gave the plaintiff to understand that it was the cause of the gangrene. The gangrene then spread to the remaining toes and dorsum of the foot. After the line of demarcation formed, the anterior part of the foot was amputated by Dr. Savage, who had taken charge of the case, assisted by Dr. Heggie, of Brampton. In a few months afterwards the ankle-joint began to suppurate, and a second am-

putation was performed above the joint. The fractured bones and amputated foot were produced in court. There was fracture of the lower end of both bones, the fracture of the tibia being comminuted and extending into the joint, and the astragalus was fractured horizontally. The principal evidence for the plaintiff besides himself, was Dr. Savage, who was positive that the whole difficulty arose from the tightness of the bandage applied to the limb. Dr. Heggie at first thought the gangrene was due to the bandage, but said it might be due to other causes. Dr. Bull's evidence favored the defendant. For the defence, the evidence of Dr. Grant, and Dr. Stevenson went to show that every care had been exercised and that the bandage was not too tight at any time. Expert testimony, consisting of the evidence of Dr. Sullivan, of Kingston, Drs. H. H. Wright, Fulton, Bethune and others, of Toronto, was also brought forward, which went to prove that the accident itself was of sufficient severity to produce the gangrene, by injuring the anterior tibial artery, and that it could not have been caused by the bandage, inasmuch as the sole of the foot was not affected, and the gangrene was of the dry, instead of the moist variety. The judge, who was unable to comprehend the bearing of the expert evidence in the case, charged against the defendant, and the jury brought in a verdict for the plaintiff with $750 damages. The case will be appealed. Comment on the unmanly and unprofessional conduct of Dr. Savage in this case is wholly unnecessary.

QUEBEC MEDICAL BOARD.

The semi-annual meeting of the Quebec Medical Board was held in Quebec on the 24th of Sept. under the presidency of Dr. C. E. Lemieux. There was a full attendance of members present. After the reading of the minutes a resolution of condolence was passed on motion of Drs. Guay and Belleau, respecting the death of Dr. J. E. Landry, a member of the Board. The report of the examiners for the preliminary examination was read and adopted. Of 34 candidates 19 were admitted. The Treasurer, Dr. E. P. Lachapelle then read his report, which showed that $5,322 had been raised during the past year, and after paying all expenses there was a balance of $1,579 on hand. It also stated that the balance on hand was being continually diminished and suggested that means should be taken either to increase the income or lessen the expenditure, and a committee was appointed to enquire into the matter. The report of the detective showed that several actions had been instituted against illegal practitioners which were still pending in the courts. Dr. R. P. Howard, presented the report of the committee to enquire into the charges brought against the professors of Victoria College by Dr. Lachapelle, of having furnished copies of the questions to their students prior to the professional examination last spring. The consideration of the report was postponed until the next meeting. Notice of motion was given that at the next session of the Provincial Parliament a petition be presented praying for an amendment to clause 3, chap. iv. of the statutes and by-laws of the College of Physicians and Surgeons of Quebec, and that the words, "without examination" be replaced by the following, viz.: "after examination," the said examination to be upon the following subjects: medicine, surgical anatomy, descriptive anatomy, surgery, obstetrics, and materia medica.

The following gentlemen received the license of the college—Drs. P. Coote, M. R. G. Matte, E. Pelletier, E. Larue, E. Gosselin, J. A. Milette, A. Morin, F. S. Caron, E. Duval, C. N. Valin, M. T. Brennan, O. Berthiaume, F. H. Daigneault, W. Fournier, H. Leduc, J. O. A. Beaupré, H. Gauthier, R. Migneault, A. Richard, H. Brosseau, J. O. Stewart, A. Stewart, C. E. Cameron, J. A. Hutchison, and B. F. W. Hurdman.

ACTION FOR SLANDER.—This was an action brought by Dr. Hunter, at the recent assizes in this city, against Dr. Freel, both of whom reside in the village of Stouffville, Ont. Dr. Hunter attended a woman in her confinement. The labor was natural and the placenta came away without any trouble. On the fourth day afterwards she had a chill which was followed by an attack of pelvic cellulitis from which she died. Dr. Hunter complained that Dr. Freel, who had been called in the day before the woman died, stated to the friends of deceased that he (Dr. Hunter) had left a portion of the placenta in the uterus, which was the cause of the woman's death. This statement was also made to several parties in the village, and hence

the action. For the defence Dr. Freel called witnesses to prove that Dr. Hunter himself stated that he was afraid a portion of the placenta had been left in the uterus, and that the friends of the deceased mentioned this to Dr. Freel. His reply was "if Dr. Hunter left a portion of the placenta in the uterus it would account for the woman's condition," and this was essentially the statement he had made to other parties in the village. Dr. Hunter and his witnesses on the other hand testified that the statement was to the effect that if he (Dr. H.) had been obliged to remove the placenta a portion might have been left and caused trouble, but under the circumstances he could not account for her condition. A large number of witnesses, lay and medical were examined on both sides, and the trial occupied three days. In his charge to the jury the judge explained that any expression of opinion by Dr. Freel to the friends was privileged, but statements made to parties outside adverse to Dr. Hunter, or with a view to injure him constituted slander. The jury found a verdict for the plaintiff and $50 damages.

APPOINTMENTS.—Dr. T. W. Mills has been appointed Prof. of Physiology and General Pathology in McGill Medical College, *vice* Prof. Osler; Dr. Wilkins, Professor of Practical Histology, and Dr. Sutherland Professor of Morbid Anatomy.

Drs. P. R. Inches, St. John, N B. and J. H. McCollum, Toronto, have been appointed medical examiners under the Civil Service Act.

CORONER.—Dr. D. D. W. Harrington, of Halifax, has been appointed coroner for the City and County of Halifax.

ACKNOWLEDGMENTS. — The Chairman of the Ontario Board of Health desires to acknowledge with thanks contributions to their reference library of hygiene from the following publishers:—D. Appleton & Co., New York; A. E. Wilde & Co., Cincinnati; Henry C. Lea's Son & Co., Philadelphia; Jansen, McClurg & Co., Chicago; G P. Putnam's Sons, New York; Houghton, Mifflin & Co., Boston; Harper & Bros., New York; Geo. S. Davis, Detroit.

AMERICAN PUBLIC HEALTH ASSOCIATION—The 12th annual session of this association was held in St. Louis, Mo., on the 11th of October and three following days, under the presidency of Dr. A. C. Ghion. About 150 members were present. A large number of interesting papers on sanitary questions were read and discussed. Dr. C. W. Covernton, President of the Ontario Board of Health, and Dr. Bryce, Secretary, were present as delegates from Canada.

MEDICAL COUNCIL ELECTIONS.—Dr. Allison, of Bowmanville, will again be a candidate for election to the Council for the Territorial Division of King's and Queen's. He has been a most able and faithful representative and we hope to see him re-elected. We know that the interests of the profession and the Council are very dear to him, and are in hopes that he will, some of these days, grant the institution a liberal endowment.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.—The following have been elected officers of this Society:—President, Dr. Roddick; 1st Vice do., Dr. Alloway; 2nd Vice do., Dr. Trenholme; Treasurer, Dr. Molson; Secretary, Dr. Gurd; Librarian, Dr. Reed; Council, Drs. G. Ross, Kennedy and Rodger; Publication, Drs. Cameron, Ross, Bell and Kennedy.

REMOVALS.—Dr. Coleman, of St. John, N.B., has removed to Baltimore, U.S., to practice his profession. He carries with him the hearty good wishes of his Canadian confreres. — Dr. Atherton, of Fredericton, N.B., has removed to this city. We welcome him to our midst and wish him every measure of success and prosperity.

TRIPLE VALERIANATE. — Dr. Goodell recommends the following in the treatment of certain nervous diseases in females:

℞ Quiniæ Valerian.
Ferri "
Zinci " *aa* grs. xx.—M.
Ft. pil. No. xx.
Sig. One three times a day.

PRESENTATION.—Dr. Aiken, of Weston, Ont., who is removing to California, on the occasion of his departure, was presented with an illuminated address, accompanied with a silver tea service for Mrs. Aiken, by his numerous friends in the village and neighbourhood.

THE NEW LOCAL ANÆSTHETIC.—The new local anæsthetic, cocaine hydrochlorate, recently discovered in Germany, is giving most astonishing and satisfactory results in the hands of specialists, as reported in the N. Y. *Medical Record.* Drs. Noyes, Agnew, Moore and Minor all speak in enthusiastic terms of its value. A few drops of a two per cent. solution is dropped in the eye three or four times at intervals during a period of fifteen minutes. The effect is to produce such profound local anæsthesia as to permit of operations, such as division of the recti muscles, being done without the patient complaining or showing any signs of pain. The new remedy is the reigning sensation in New York among specialists.

STAMP CANCELLATION.—We learn from the *Daily Star* that Dr. Griffin, of Montreal, has invented an instrument for cancelling postage stamps. It is stated that the loss to the governments of Canada and the United States through inefficient stamp cancellation, ranges from $10,000 to $50,000 respectively. The instrument will be tested in the Montreal post office, and if found satisfactory will be adopted generally. The instrument cuts a piece out of the stamp, but does not go through the envelope.

THE BRITISH CHOLERA COMMISSION. — The Commission, of which Dr. Klein is the principal, are busily prosecuting the work in Bombay, and have made experiments with the microbes which led them to doubt the infectious nature of Koch's cholera microbe. Dr. Klein has shown his contempt for the microbe theory by swallowing a number of so-called cholera bacilli without any ill-effects.

COMPLIMENTARY DINNER.—The medical profession of Montreal gave a complimentary dinner to Dr. Osler prior to his departure for Philadelphia. The chair was taken by Dr. R. P. Howard, and about fifty members were present, all of whom united in wishing their guest abundant success and prosperity in his new sphere of labor.

MUNIFICENT DONATION.—A donation of half a million dollars has been given to the College of Physicians and Surgeons, New York, by Wm. H. Vanderbilt. This is an example of generous and public-spirited liberality which is worthy of the highest commendation. It is to be hoped that it is only the beginning of good things in store.

Books and Pamphlets.

THE LAND OF BURNS, and other Pen and Ink Portraits. By J. Campbell, M.D., Seaforth, Ont.

This interesting work by Dr. Campbell will be issued from the press in a few weeks, and the profession will, we are sure, be pleased to patronize it. The subject is an inviting one, and the author is quite competent to make it entertaining. We bespeak for the author and the work the kind consideration and patronage of the profession in Canada.

HOOPER'S PHYSICIAN'S VADE MECUM; with an Outline of General Pathology, Therapeutics and Hygiene. 10th edition. Revised by William Augustus Guy, M.B., Cantab, and John Harley, M.D., London, F.L.S. New York: Wm. Wood & Co.

The original work of Dr. Hooper, published as far back as 1823, has been such a great favourite with the profession, that every few years the proprietors of the original copyright have placed it in the hands of successive editors, by whom it has been brought down to the present level of the various subjects treated on. The work, as now presented to the profession, may be recommended as a useful reference to all items of information in clinical medicine, to both student and practitioner. Both volumes are largely illustrated by wood engravings, and an extensive collection of formulæ, preceded by classified lists of the British Pharmacopœia, with their doses, is added.

MATERIA MEDICA AND THERAPEUTICS. By Mitchell Bruce, M.A., M.D., London. Philadelphia: H. C. Lea's Son & Co.

This hand book is one of the very best of an excellent series. It is new, condensed and eminently practical in its character. It is divided into three parts: I. The inorganic. II. The organic materia medica. III. General therapeutics. This book, small in size, but large in the amount of information it contains, is sure to have a large sale.

Births, Marriages and Deaths.

On the 15th ult., J. E. Brouse, M.D., of Brockville, Ont., to Amelia Mary, only daughter of P. L. Allen, Esq., of Hamilton, Ont.

On the 28th ult., the beloved wife of Dr. J. Fulton, editor of the CANADA LANCET, Toronto, aged 40 years.

On the 1st ult., Dr. J. A. Aikman, of Ingersoll, Ont.

On the 21st ult., Dr. J. S. Diamond, of Toronto, aged 45 years.

THE CANADA LANCET.

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Original Communications.

NOTES ON FIVE CASES OF OVARIOTOMY.

BY A. B. ATHERTON, M.D., L.R.C.P. & S., ED., TORONTO, (Formerly of Fredericton, N.B.)

CASE I, *March 12, 1876.* — Mrs. H., æt. 49, never menstruated but once in her life, when 17 years of age. Had distinct menstrual molimen every month, however, till four or five years ago. Married at 22 years. Husband died seven years ago. Three years ago noticed first a tumor in left inguinal region. Was examined by me about a year afterwards, when it was of size of adult head, and I diagnosed ovarian tumor and advised her to have it removed when it got somewhat larger. Nearly a year after I saw her it had become so large that another medical man who was consulted tapped her. Since then he has repeated the operation some six or seven times. As the tappings have of late been required at shorter intervals than at first, and as her health has been failing, she called me in again to see her. She was induced to do this, more particularly, because of the opinion of her attendant that the tumor could not be removed.

On examination I found the whole abdomen filled with a fluctuating tumor, also her legs were considerably œdematous, and she had become much emaciated. I advised her to submit to ovariotomy at once, but she begged me to postpone that operation for the present and tap her again. I complied with her request and drew off eight quarts of thick mucilaginous liquid. I tapped her again on May 4th, June 14th and July 16th, removing sixteen quarts in the last tapping.

August 20.—Thinks she is as large as before last tapping and consents to removal of tumor. To have castor oil to-morrow to move the bowels.

Aug. 22, 11 a.m., Operation.—Chloroform administered, followed by ether; assistance rendered by Drs. Coulthard and Ellis, of Fredericton. A long incision had to be made, extending two or three inches above umbilicus, to get out the solid portion of the tumor, which weighed eight pounds, and was so firmly adherent to the omentum that about nine inches of the latter had to be ligatured. The adhesions to other parts were unimportant. About eighteen quarts of fluid matter were got away by tapping, making the whole tumor about forty-four pounds in weight. It grew from left side. Pedicle secured by clamp externally and sutures put in. Stump powdered with salicylic acid and wound dressed with carbolized oil, cotton wool pad, and bandage being applied over all. Half a grain of morphine suppository given after coming out of ether.

Aug. 30.—Wound has been dressed every day as at first. Temperature reached more than 100° F. only once since operation; 100.5° F. on second day. Has not suffered much pain; taken five or six opiates; no vomiting; sutures were all removed yesterday.

Sept. 2.—Doing well, but bowels have not been moved till to-day, although she has had several enemata during the last few days. A dose of castor oil yesterday, followed by another enema this morning, has had the desired effect.

Sept. 7.—Clamp came off this morning. Doing well.

Sept. 12.—Is up, dressed, and going about the room.

Sept. 18.—Has been down stairs the last two or three days. Some granulations still at site of stump; nitrate of silver applied.

Sept. 27.—Wound healed; has been out of doors.

Nov., 1884.—Has been living in Boston the last five or six years, and has been in good health ever since operation.

CASE II, *March 21, 1878.*—Mrs. R. D., æt. 49, mother of four children, youngest nine years of age; husband living. Health generally good till one year ago, when she felt a lump in hypogastrium, accompanied with soreness. During last summer had two attacks of severe pain in abdomen, which obliged her to keep her bed about a week each time. Tumor has gradually, though irregularly, increased up to the present. Catamenia have been somewhat irregular, both as regards time and quantity. For the last month the appetite and general condition have failed, and she

now presents an emaciated and careworn appearance. Has consulted five different medical men in towns of New Brunswick and the State of Maine, who all seemed agreed that she was suffering from a tumor which was "connected with the womb," and gave it as their opinion that it could not be removed. Her family physician called her husband to one side just as they were starting from home to consult me, and told him that if she was operated on she would be brought back a corpse.

On examination I found a large hard tumor occupying the whole of the lower abdomen, somewhat irregular on its surface, and at one or two points indistinctly fluctuating. Slight resonance in left lumbar region; dull elsewhere. Per vaginam: os tincæ felt directed somewhat posteriorly, and sufficiently patulous to admit the tip of forefinger. Fundus of uterus anteflexed, and tumor pressing closely down upon it; the two seemed to move together more or less in all directions. Sound could be passed only one inch. When the tumor was however lifted well upwards by Dr. Coburn, of Fredericton, who assisted me at the examination, I could enter sound the normal distance by directing it well anteriorly, and I then found that the uterus and tumor could be moved more or less independently of each other. On aspirating tumor at a point which seemed to be more fluctuating than the rest, a small quantity of thick mucilaginous fluid was got. I therefore diagnosed an ovarian tumor, and advised operation. While resting after her long journey for a few days, the catamenia came on.

March 31, 11 a.m., Operation.—Chloroform administered, assisted by Drs. Coburn and Ellis. Incision below umbilicus and tumor tapped. Only a pint or two of fluid got away, and I therefore extended incision upwards to above navel. Some adhesions on the front and left side, were readily broken down, and the tumor delivered. Clamp applied to pedicle and secured externally. Sutures; carbolized oil dressing, with cotton wool and bandage. Pedicle sopped with tinct. benz. co. Half a grain of morphine suppository after operation.

April 5.—Wound dressed every day as at first. Has required four or five opiates; considerable vomiting for the first thirty-six hours; attributed it partly to the milk given. Since then has eaten soda biscuit and tea. Temperature has not risen above 99.2° F. since operation. May chew a little beefsteak to-day. Two sutures removed.

April 7.—Abdomen has been considerably distended for the last day or two, and yesterday evening pulse and temperature ran up to about 100° F. No great pain or tenderness, however. All sutures removed yesterday. Patient feels as if bowels ought to be moved, and I therefore ordered oil, to be followed in a few hours by enema.

April 8.—Bowels moved twice with some griping last night, and I ordered quarter grain suppository of morphine, which caused her to rest well till morning. Pulse 76, temp. normal. Some suppuration in stitch holes.

April 18.—Has done well since last report. As clamp has not come away, and the stump is swelling rather badly, I cut the latter close beneath clamp and took it away. There was no bleeding, as the parts were completely dead.

Nov., 1884.—As far as known, continues well to date.

CASE III, *Oct. 24, 1878*.—Miss T. R., æt. 18. Health usually good; catamenia always regular since 13. First noticed some enlargement of abdomen last February. Consulted Dr. Holden, of St. John, N.B., in June, who diagnosed ovarian tumor, and treated her first with iodide and bromide of potassium; of late he has put her on tonics. Abdomen has steadily enlarged, till now it measures thirty-three inches around umbilicus. It fluctuates everywhere. No marked change from health in the general appearance, but she has suffered a good deal of pain in part for a few days past. Ordered opiates pro re nata.

Oct. 27.—Has required quarter grain doses of morphine two or three times in the twenty-four hours; vomiting has been somewhat troublesome from it. Pulse 96, temp. normal.

Oct. 30.—Pain not so severe; pulse 108, temp. normal.

Nov. 4.—Pain has subsided; pulse 96.

Nov. 9.—Chloroform given and a vaginal examination made. Cervix uteri was in normal position. Anteriorly, a firm mass filled roof of pelvis. The hymen being perfect, this examination was not very satisfactory.

Nov. 11.—To have half an ounce of castor oil to-night, followed by an enema in the morning.

Nov. 12, 11 a.m., Operation.—Chloroform ad-

ministered, assisted by Drs. Holden and Coburn. Incision made, under carbolic spray, four inches long, between umbilicus and pubes. Tumor tapped and about ten quarts of thick syrupy fluid removed. No adhesions. Tumor grew from right ovary. Pedicle ligatured with carbolized silk and dropped in. About half a dozen sutures put in, and dressed with carbolized gauze. Adhesive straps over this, and cotton wool and flannel bandage. Half a grain of morphine suppository, together with quarter grain hypodermically, was required to relieve pain after the operation.

Nov. 15.—Dressing changed for first time under spray. Wound looks well. Has complained a good deal of pain in abdomen and down right thigh since operation, for which she has had two or three opiates per day. This has seemed to keep up some vomiting, but the temperature has only been up to 100° F. once, on the morning of the 13th. Pulse now 104, temp. 99.5° F.

Nov. 18.—Doing well; no opiate since the 16th. An enema brought away some fæcal matter and a good deal of wind yesterday.

Nov. 19.—Wound dressed; sutures removed. Small spontaneous motion of bowels to-day.

Nov. 22.—Wound dressed with adhesive plaster. No pus has been seen at any time.

Nov. 29.—Sitting up for last two days. Pulse 100, temp. normal. As bowels have not moved for several days, some citrate of magnesia was ordered.

Dec. 4.—By dint of citrate of magnesia, castor oil, and enemata, a large quantity of hardened fæces has been got away during the last few days.

Dec. 14.—Doing well; is about house. Gaining in flesh and strength.

Nov., 1884.—Was married a little more than three years ago, and has since borne two children.

CASE IV, *March 13, 1879.*—Miss M., æt. 27. Came to me from the country yesterday; gives as a reason for not coming before, that the doctor in her neighborhood always told her that nothing could be done for her. As she began to think that death must soon come, she decided as a last resort to consult me. Was generally healthy till six years ago, when she first noticed an enlargement of the abdomen. No distinct lump ever felt. She has steadily increased in size till she now measures seventy-two inches around body at umbilicus, sixty-six inches around waist, and fifty-six from one anterior superior spinous process of ilium to the other. Has not suffered very much pain, and has had no difficulty with bladder or bowels. The catamenia grew gradually more and more scanty, till they ceased about two years ago. The upper part of her body is extremely emaciated, while the abdominal walls and legs are immensely swollen. Many large veins course over abdomen. The lower end of sternum is pressed so much outwards that it stands at right angles to axis of body. When standing on feet the œdematous abdomen reaches quite down to upper edge of patellae, and when she sits, it rests upon the seat of chair between the thighs. The upper half of abdomen distinctly fluctuates, but the great œdema below prevents my getting this sign clearly. Per vaginam, the hymen acts as an obstacle to a satisfactory exploration. Per anum, a soft doughy mass can just be touched with finger at roof of pelvis. Pulse 120, weak and thready.

March 14.—Thinking it better to tap the tumor, and thus take the pressure off the kidneys and allow them to remove the anasarcous condition somewhat before proceeding to abdominal section, I passed in a long curved trocar with point downwards, and drew off seven gallons of thick treacly-looking fluid. The size of patient did not seem much reduced by the operation. At the end of the flow there came away about an ounce of purulent-looking fluid.

March 15.—Patient rested pretty well last night, but complains a good deal of soreness, which she thinks is largely due to my keeping her quiet in bed since yesterday. She therefore asks to be up, as is her custom. I consented, with the understanding that she should not move about the room. Measurement is now sixty-two inches about umbilicus, and fifty-seven inches around waist. Pulse as before. A slight hacking cough, which has troubled her for a few months, has left her since the tapping. This is probably due to removal of pressure from lungs.

March 19.—As there seems to be little or no improvement in patient's general condition, and as she is urgent for an operation, I agree to remove tumor on the morrow; bowels to be freely opened previously.

March 20, 11.30 a m., Operation.—Ether administered, assisted by Drs. Coulthard, Coburn and Ellis. On making incision I found tumor exten-

sively and firmly adherent in front and right side, to abdominal wall; and this, together with the great size of the solid portion of tumor, necessitated a wound reaching nearly from ensiform cartilage to pubes. Several gallons were got away by tapping, and after three or four hours' hard work, the whole tumor was removed. Pedicle was ligated and dropped in, mass being cut away from left side where it grew. A considerable amount of blood was unavoidably lost during the operation, and brandy had to be given both by mouth and rectum while it was going on. Large rubber drainage tube put in at lower wound, and sutures introduced as usual. Operation was done under carbolic spray, and the wound was dressed with carbolized gauze. Strapping, cotton wool, and bandage over it. Ninety-one and a half pounds of tumor removed, thirty-nine and a half pounds constituting the solid portion. *6 p.m.*—Pulse feeble, and occasionally intermittent; a good deal of restlessness. Two drachms of laudanum and half an ounce of brandy given in water by the rectum. *7 p.m.*—Sleeping quietly. Pulse rather better.

March 21, 9 a.m.—Pulse 140, feeble, but regular. Extremities warm. Has had brandy, milk and egg, by both mouth and rectum during night. Urine drawn; it looks well. *12 m.*—Pulse 148. Considerable serous discharge on dressings, which were therefore changed. *3 p.m.*—Pulse more feeble. Some delirium. *4.30 p.m.*—Pulse absent at wrists. Extremities growing cold. *9 p.m.*—Died. Abdomen examined; no hæmorrhage.

CASE V, *March 28, 1883.*—Mrs. A. G., æt. 50. Multipara. Has not been very strong since marriage, thirty years ago. Had a "fever" when pregnant seven months with first child, and miscarried at eight months; child living. Thinks she has never entirely recovered from the effects of that illness. Has had more or less dysuria for years, though urine, she states, generally looks healthy. More troublesome than ever since two years ago, at which time she thought there was a tumor in the vaginal passage. Eighteen months ago, underwent an examination by a physician of a neighboring town, who told her that she had a "fibroid" tumor of size of fist at the back of womb. Catamenia have been tolerably regular, though she sometimes has gone beyond the four weeks. Appetite has been poor of late. Abdomen is now about size of that of a woman at full term. This enlargement is due to a hard irregular mass, most prominent on right side. Very little if any fluctuation can be detected in it, though in parts it seemed somewhat elastic. Per vaginam, uterus felt at right anterior pelvis. Sound enters normal distance. A mass, similar to that felt through abdominal wall, and apparently continuous with it, found pressing down well into pelvis posteriorly. Uterus moved independently of tumor. Lumbar and epigastric regions alone resonant on percussion. Pulse 84, temp. 99° F.

April 6.—Catamenia appeared the next day after last examination, being the proper period for them. Pulse 88, temp. 99.

April 9.—Took a cathartic yesterday evening, preparatory to an operation, and had two loose stools accompanied with some griping. Paregoric relieved latter. Pulse 92, temp. 100.

April 11, 12 m., Operation.—Chloroform administered, followed by ether. Assisted by Dr. Coburn, and Mr. J. G. Owens, my medical student. Carbolic spray used. Incision from just above umbilicus to near pubes. Tumor tapped and about three quarts of thick material got away. The solid portion, weighing about seven pounds, was then removed. No adhesions of importance. Tumor grew from left ovary. Pedicle ligatured with silk and dropped in. Wire sutures. About a dozen catgut ligatures had to be applied to various bleeding points of wound in abdominal wall, long continued pressure with forceps not controlling the hæmorrhage. Carbolized gauze, etc., as in cases 3 and 4. Suppository, containing half a grain each of morphine and ext. belladonna, administered. On examination of tumor nearly a pint of thick, flaky, purulent matter found scattered through its solid portion.

April 12, 9 a.m.—Rested fairly. Pulse 92, temp. 100. Vomited only once. *9 p.m.*—Pulse 96, temp. 100.8.

April 13, 8 p.m.—Pulse 76, temp. 99.4. Some menstrual flow appeared to-day.

April 14.—Pulse 72, temp. normal. Wound dressed under spray.

April 19.—Bowels were moved by enema two days ago. Sutures removed to-day under spray. Wound about healed. Pulse 76, temp. 98.6.

April 25, a m.—Patient sat up for an hour last evening; while up she suddenly got chilly, and was obliged to go to bed at once and be covered

up warmly to avoid a rigor. Some pain was complained of in left side running up towards axilla, which was relieved by half a grain of morphine suppository. Not much pain this morning, but pulse is 100 and temp. 101.4. *6.30 p.m.*—No great pain to-day. Pulse 110, temp. 103.4. Wound is all right, and there is little or no distension in, or marked tenderness of, abdomen. Nothing wrong per vaginam.

April 27, 9 a.m.—Has had half a grain of morphine suppository and rested fairly well. Pulse 104, temp. 101.4. *8 p.m.*—Pulse 100, temp. 103.2.

April 28, 9 a.m.—Has perspired rather freely this morning Pulse 80, temp. 99.2. *8 p.m.*—Pulse 84, temp. 101.6.

April 29, 10 a.m.—More free perspiration last night. Pulse 76, temp. 98. *9 p.m.*—Sweating continues. Pulse 72, temp. 98.

May 2.—Has been doing well since last report, and has returned to solid food with a relish.

May 12.—Left for home, about 90 miles away.

Nov., 1884.—As far as I am aware, has remained in good health up to the present time.

REMARKS. — There are several points in the above cases which are worthy of notice. In the first place, in four out of five the long incision had to be made in order to get out easily the solid portion of the tumor. The favorable result in three out of the four would rather indicate that the increase of risk is not so much as generally believed when the incision is extended above the umbilicus.

Secondly, the much abused clamp was used to secure the pedicle externally in the first two of these, and they both did exceedingly well.

Thirdly, the presence of pus in Cases 3 and 5, showed that before long there would have been an escape of matter into the peritoneal cavity, and consequent death.

Fourthly, the immense size of the tumor in the patient who died. I removed at least 147½ lbs. from her in six days; and supposing the sac re-filled to the extent of 20 lbs. during those days, the tumor must have originally weighed 127½ lbs. I may mention that Dr. Thomas Keith, to whom I related this case last April, considered 20 lbs. a liberal allowance for its increase during that period. My own impression is that I gained nothing by the preliminary tapping in that case, for I think that she was if anything weaker *after* it than *before* it; and I attribute her increased weakness (whether rightly or wrongly) to the rapid re-filling of the emptied cyst, causing a great drain upon the nutritive principles of the blood. If I should ever meet with such an enormous tumor again, I would at once proceed to ovariotomy.

Finally, the feverish turn which occurred in Case 5, was, I believe, due to some kind of blood poisoning, causing a short continued fever. I had noticed on several occasions, both before and after its occurrence, a foul smell in the hall adjoining her room. I had called the nurse's attention to it, but neither she nor I could ascertain the source of it. I can't help thinking that this had something to do with her febrile attack. There was nothing at any time in the wound, or, as far as I could detect, in the abdomen, to account for it. It will be observed that her temperature reached only one evening as high as 100.8° F., in the first week after the operation, while during the second week it had been normal. It could therefore be scarcely possible after such a period of favorable convalescence, that the operation had anything to do with the febrile attack. I may say that this patient was one of those who are very gloomy, and she fully expected not to live beyond the ninth day. She disclosed this fact to me only after that day had passed, although she had me sent for hastily on several occasions during the 8th and 9th days, imagining that her time was at hand.

I may further observe that in all these cases I had no skilled nurse to look after the patients, not even one who had done other kinds of nursing; so that it is evident one may get very fair results in ovariotomy in remote districts where such are hard to procure, as well as in hospitals peculiarly equipped for such operations. I am free to admit, however, that the assistance of a nurse accustomed to the care of such cases, would lessen materially one's own anxiety and the amount of attention required to be given to them.

A CASE OF DOUBLE NARCOTIC ADDICTION.—OPIUM AND ALCOHOL.—IMBECILITY—RECOVERY.

BY J. B. MATTISON, M.D., BROOKLYN, N.Y.

Through the courtesy of Drs. T. Gaillard Thomas, of New York, and Wm. Bayard, of St. John, N.B., there came under the writer's care last

year a case of combined opinm and alcohol taking, presenting a history and result of such importance as probably to render its recital one of interest to the readers of the LANCET.

Mrs. ——, of Canada, æt. 34, in the summer of 1881, passed through her second accouchement during the eighth month of gestation. Her recovery was tedious, involving four to five months, during which she had much discomfort from alvine torpor, and also underwent an operation for the relief of fistula in ano. The latter was attended by severe pain, to relieve which her medical adviser gave morphia hypodermically, and supplying her with a syringe instructed her and the attendant in its use. This was in July, and the initial dose of the morphia was ⅛ of a grain, repeated three or more times daily, when the pain was severe. She made a fair recovery from this illness, except that the power of her lower limbs was largely lost, due, it was thought, to the morphia—which she had steadily taken—and a lack of active exercise. She had now become a confirmed habitué, and during the next two years used her opiate in increasing quantity and frequency, often repeating it every three or four hours.

During the autumn of 1883 she came under the care of a medical gentleman who was called to relieve her of severe abdominal pain and nervous derangement. Prior to this time no attempt had been made to abandon the morphia. Her new medical adviser, appreciating the situation, strongly urged an effort in that direction, but without success. Her condition had steadily grown worse, aggravated as it was by an inordinate use of brandy, of which she took at times from 12 to 16 ounces daily. From October, 1883, her mental and physical decline was marked, the most prominent symptoms being anorexia, insomnia, nausea, incessant thirst, subsultus, loss of memory, delirium, hallucinations and partial imbecility. Her physician now insisted on stopping her stimulants, and succeeded with the brandy, while the morphia, which had been increased to several grains, three to five per diem, was reduced to one or two injections daily. Despite this treatment her mental and physical status steadily deteriorated until she became completely imbecilic, and in this condition, on December 21, 1883, she came under the writer's care.

So weak was she prior to leaving home that some of her friends deemed it hazardous to make the effort, fearing she would not survive the journey, but under the watchful care of Dr. Bayard, it was safely effected. Her physical debility on arriving was so great that she was carried from her carriage. Mentally she was a wreck. Delusions were prominent, and hallucinations of sight, sound and touch almost constant, that of touch being especially marked, patient fancying bugs and reptiles crawling over her. Her expression was idiotic; she was utterly unable to converse intelligibly, and her voice in speaking speedily sank to a whisper and was lost. In fact such mental ravages from opium we never met. Physically, she was partially prostrated, pulse frequent and feeble, marked anorexia, furred tongue and alvine torpor; in fine, all the symptoms before noted except delirium and subsultus. During her coming, in order to maintain her strength, she had taken milk punch freely, and was given one or two half grain injections of morphia daily. Such was her status on arrival. There was no history of hereditary insanity. The case seemed clearly one of profoundly pernicious results from her double addictions, aggravated by a laudable effort to remove the cause. This being our belief, the prognosis was favorable, an opinion endorsed by Dr. John C. Shaw, Superintendent of the King's Co. Insane Asylum, who was called in consultation, and verified by the result, as the further record of the case will show.

As a prelude to active treatment the patient was given a mild mercurial which acted well. No alcohol was allowed from the outset, and at the end of a week the morphia—which previously had been given in small doses by mouth at bed-time—was quite abandoned, and reliance placed on large doses of Indian hemp to secure sleep. As tonics she was given daily seances of electricity, with syr. of the hypophosphites of iron, strychnia and quinine, in two drachm doses, ter die, and full feeding. The good effect of this *regime* soon declared itself, for in less than a fortnight, signs of improvement presented. The earliest of these were mental. The delusions lessened and the hallucinations departed, the last to leave being those of touch which persisted for some time after the patient was able to realize that they were only the vagaries of her disordered brain. With this amendment came a better brain status in other

ways. The imbecilic look gave place to one of increasing intelligence; the power to converse rapidly returned, and within six weeks all mental aberration had vanished. Meantime, the physical condition gradually improved, though not so speedily as the mental. The appetite was slow in returning, but her muscular strength, especially in the lower limbs, the loss of which for two and a half years, had prevented exercise, increased steadily, so that at the end of eight weeks she was able to take walks, drives, go shopping, attend church, etc., in fact, more out of door exercise than she had enjoyed for years. Her improvement in every way was notable and persisted with little interruption until March 4—nearly eleven weeks from the date of her coming—when she left our care. Tidings, direct and indirect, of late received, report her doing well.

This case presents several points worthy of detail. Its origin affords added proof in support of views exprcssed in "The Genesis of Opium Addiction," Detroit *Lancet*, Jan. 1884. But it must also be said that, in our judgment, the course of the medical gentlemen in supplying this patient with a hypodermic syringe and solution of morphia, with instructions for self-taking, unless absolutely unavoidable, was—to put it mildly—exceedingly indiscreet. Such action and advice are almost certain to end in addiction; the effect, even under professional attention, is, too often, disastrous, and the chance of escaping, when left to caprice of the patient, is small indeed. We believe that patients should *never* be allowed to give themselves injections, if at all possible to avoid it.

When her initial illness ended, this patient was an opium habitué. A much more limited time than that will often suffice. We have repeatedly known as many weeks to beget addiction, and the most marked examples of this were among those in whom it might be supposed the least likely to occur—physicians. Increased experience serves only to strengthen the writer's opinion, as expressed in a paper on "Opium Addiction among Medical Men," that "any physician using morphia, daily or oftener—especially hypodermically—for four weeks incurs great risk of becoming an habitué; indeed we think a still shorter usage might, with some, prove a snare." This case adds another to the instances in which addiction to one narcotic tends to excess in another. While these are infrequent as compared with those in which one is used, they are sometimes quite notable. We recall that of a Canadian gentleman who some time ago consulted us, who had taken for several years 10 to 20 grains of morphia subcutaneously, 60 to 90 grains of chloral, and 1 to 2 pints of whiskey, daily. Physical examination disclosed organic heart lesion, and care of his case was declined. As a rule, the ruinous results exceed those of a single addiction, while the prospect of permanent cure is always less hopeful. In our patient the pernicious effect on the brain was notable—more so than we have ever seen. While deviations from normal cerebral action are sometimes observed in cases of confirmed opium taking, it is rare that they are so pronounced as in this instance. Doubtless they were aggravated by the alcohol, yet morphia was the main factor. And it is of interest to note that the attempt at renouncing the narcotics intensified the mental disorder. Obersteiner—*Brain*, Oct., '82—demurring to Levinstein's statement that the psychical disturbances caused by morphia cease within a few hours, affirms that "mental diseases arising in the course of morphinism are of the most intractable kind when once fully developed. Not only do they not disappear on depriving the patient of morphia, but they then usually get worse."

This case tends to prove the latter part of his statement. As one medical gentleman informed us—"The condition in which you saw her was the result of the addictions aggravated by the attempt to quit them." But the mental disorder was *not* of the "most intractable kind," for improvement was prompt and progressive, much more so than anticipated, as it was thought several months rather than weeks would be needed to repair the damaged brain.

Regarding alienation caused by opium, Obersteiner thinks it frequent, asserting that "a man who consumes large quantities of morphia during a number of years will display many nervous symptoms, and that the continued intoxication attacks the psychical much more constantly than the somatic life." He further states: "The degree of mental aberration arising from protracted use of the drug is very variable. There may, indeed, be individuals who retain their power of mind in spite of it, but the number is much greater of those who betray a marked alteration of their intellectual and

moral life; and in not a few cases finally the point of distinct aberration is reached. This usually consists of a depressed state, with suicidal tendencies, occasionally with violent excitement and hallucinations;" and he sums up his views with the statement that "In most cases the protracted use of morphia in large doses is followed by psychical alterations of a lasting nature, which may amount to decided insanity."

With these opinions we are not in full accord. Our experience has been much more favorable. We have observed many cases of opium addiction, among them those who had taken morphia in large amounts for several years, yet the number with marked mental derangement has been small. Depression has been common; so, too, irritability of temper; but we recall only one instance in which suicidal or homicidal tendency existed, and but a single case that we deemed "decided insanity." Far oftener physical symptoms presented. In some form, these have been almost constant, so that, on this score also, our observation has been at variance with Obersteiner.

Regarding treatment, one point deserves special mention—that is, the effect of Indian hemp in large doses. In this instance it quite maintained the power ascribed to it by Moreau of removing hallucinations. Again and again, often by the patient, was this noted. Its hypnotic action also was very satisfactory. As a soporific, in ex-opium habitués, cannabis indica is of great value. They may be peculiarly susceptible to its good effect, but certain it is we know of nothing equalling it, and employ it almost exclusively. For details regarding its use, *vide* "The Treatment of Opium Addiction," *Courier of Medicine*, Dec., 1884. Finally, the history of this case is of value as warranting hope of entire recovery under conditions that, seemingly, offer little promise of success.

COCAINE AS A LOCAL ANÆSTHETIC.

BY A. M. ROSEBRUGH, M.D.

Surgeon to the Eye and Ear Dispensary, Toronto.

The surprising effects which have been attained during the last few weeks, with the muriate of cocaine, has led me to collect some facts in regard to it, for the benefit of the general reader.

Cocaine hydrochlorate is prepared from the leaves of the *erythroxylon coca*. The plant grows wild in the mountains of Peru and Bolivia in South America, where it is used instead of tobacco. It is estimated that thirty millions of pounds per annum, are consumed by the natives who chew the leaves made into a ball mixed with lime. When used in moderate quantity, it is said to increase nervous energy, enliven the spirits, and enable the person to bear bodily exertion, exposure, and want of food to a surprising degree.

The physiological action of the alkaloid (cocaine formula C_{17} H_{21} NO_4) is apparently identical with that of theine, and caffeine. The alkaloid was discovered in 1855. In large doses it produces cerebral excitement, complete paralysis of sensibility, tetanic spasms, and death. It paralyzes the entire posterior column of the spinal cord and the entire system of peripheral sensory nerves.

The hydrochlorate of cocaine has been used for over two years for the purpose of reducing the sensitiveness of the larynx, but it was not until about the first of September last that its anæsthetic effect upon the conjunctiva and cornea was discovered. The honour of this discovery is due to Dr. Koller, a young physician of Vienna. The discovery was announced at the meeting of the International Ophthalmological Society, held in Heidelberg September 15th and 16th, the report of which appeared in the *N. Y. Medical Record*, October 11th, and in the *Ophthalmic Review*, a little later. Since then the anæsthetic properties of cocaine in ophthalmic as well as in some other branches of surgery has been very thoroughly tested, and with the most gratifying and surprising results. Up to the present, the only salt of cocaine used is the hydrochlorate which is used in solution of from 10 to 20 grains to the ounce. For producing anæsthesia of the conjunctiva and cornea, from two to four drops are applied every three or four minutes until from eight to twelve drops are used. Partial anæsthesia commences within two minutes of the first application, reaches the maximum in about fifteen minutes, and disappears in twenty-five or thirty minutes. Under its influence, the eye-speculum may be introduced, the conjunctiva seized with the fixation forceps, the eyeball fixed in any position, and all the ordinary operations may be performed without pain. When the solution is applied only superficially the anæsthesia does not seem to extend to the ocular muscles or to the iris. Before perform-

ing tenotomy ether for strabismus or for enucleation, the hypodermic syringe is used, and before excising a section of the iris the cocaine solution is allowed to enter the anterior chamber through the corneal wound. I have found cocaine useful in facilitating exploration of the eye. This is of special advantage in treating children and highly sensitive patients. It relieves photophobia and removes the dread of manipulation. Whether or not it possesses actual therapeutic value remains to be seen. It will be at least a valuable adjunct to other remedies.

In addition to its anæsthetic properties, it dilates the pupil and diminishes the power of accommodation. As these effects all disappear in a few hours, cocaine will probably supersede atropine for ophthalmoscopic examinations, and especially so as I find that the eye is more tolerant to the light of the mirror when under its influence.

Cocaine hydrochlorate has already been applied as an anæsthetic and with encouraging results, to the mucous lining of the nasal cavities, the pharynx, the urethra and vagina. Under its influence the actual cautery has been applied to the turbinated bones, the catheter has been introduced into an unusually sensitive male urethra, and operations have been performed upon the os uteri, with little or no pain.

Cocaine has been found to contract the venous sinuses underlying the Schneiderian membrane, hence it is suggested as a remedy in acute, coryza hayfever, and epistaxis. It also exerts a controlling effect upon the painful affections of the eye, as in iritis, in the phlyctenular diseases, and after operations and injuries; and it has been used with success in painful affections of the ear.

The price of the new remedy one month ago was as high as one dollar a grain, but it can now be obtained for 50 cents. The price is still too high to admit of its general use, but in important operations such as iridectomy and extraction of cataract, where general anæsthesia is attended with serious drawbacks, cocaine would not be too dear at one dollar a grain; and even at that price the cost would not be greater than in using the best sulphuric ether.

QUININE AND ERGOTINE.—Ergotine neutralizes the cerebral effects of quinine. Tinnitus may be entirely avoided by combining these two remedies.

COMPOUND FRACTURE OF THE SKULL, ESCAPE OF BRAIN SUBSTANCE, RECOVERY.

BY H. ROSS, M.D., CLIFFORD, ONT.

Permit me to give a few details of a case that occurred in my practice between three and four months ago. R. B., æt. four years, while playing on the lower steps of an outside basement stair at the rear of the dwelling, was struck on the head in the right frontal region by a brick which fell from a second storey window, a distance of eighteen feet. The child fell but rose again almost immediately, ascended the stair and was finding her way into the house, when met by her mother.

I saw the case a few minutes after the accident. The child had vomited two or three times before I arrived, but showed no other symptoms of having received a severe injury. On examination, I found a scalp wound about an inch and a half in length, which had bled freely, and amongst the hair a quantity of brain matter, in all about the size of a large marble. The mother had previously wiped a quantity of blood and brain matter from the wound. In the then excited state of the child, I found it impossible to make a proper examination of the wound, or with any degree of safety to ascertain the extent of fracture, without the use of an anæsthetic. I therefore sent for Dr. Stewart, of Palmerston, to assist me, and in the meantime placed the head in the position most favorable to drainage; applied cold to the head by means of iced water conducted through a bladder by rubber tubes of entrance and exit, provided with stopcocks to regulate the supply. And as there were no symptoms of depression or shock, except perhaps the vomiting, I gave a sharp purge of calomel and jalap. On the arrival of Dr. Stewart, we chloroformed the patient, and on examination found the fracture to be about one inch longer than the scalp wound and situated three or four lines lower on the frontal bone, owing probably to an oblique position of the head when struck. There still remained debris of brain matter between the edges of the wound, and on closer examination, the strongly pulsating torn end of an artery (a branch of the anterior or middle meningeal, most likely the latter), which had been ruptured by the injury, was seen projecting from between the edges of the

fracture. The lower edge of the line of fracture was found depressed the entire thickness of the skull, and the vessel appeared to be compressed by the edges of the fracture to an extent sufficient to prevent hæmorrhage. It is reasonable to suppose that the depressed edge of the fracture recovered its position to some extent after the injury, partly from its own resiliency and partly from brain pressure, so that the hæmorrhage which had apparently been free at first, was arrested by the pressure exerted on the bleeding vessel by the re-approximation of the edges of the fracture. The peculiarity of this case is, not the recovery of the child, for recovery is not so rare an occurrence, especially in children, after brain injuries with loss of brain substance; but what seems singular in the case is the fact, that with the one exception of vomiting, the child never gave any indication of having received a severy injury of any kind, from the day of the accident up to the present time. She never betrayed the slightest want of intelligence from first to last, and a few minutes after the accident, as well as throughout her confinement to the room up stairs, readily recognized the voices of her associates who were playing on the street below. It seems to me, the only reasonable explanation of the absence of brain symptoms, and one which is concurred in by Dr. S., is that the extrusion of brain substance caused by the continued action of the violence which produced the injury, while relieving to some extent the brain pressure, by carrying with it the already severed artery, also saved the child from the immediate and remote effects of extravasated blood in brain tissue. I need scarcely say, that in the absence of symptoms, and of any spicula of bone which might irritate the brain, we did not interfere with either the fracture or scalp wound, but secured perfect quiet in a moderately darkened room, a position favorable for drainage, the continuous application of cold to the head for many days, regular action of the bowels, and the use of cold water dressing to the wound, which healed kindly in a short time; and after a few days it was with difficulty that the little patient could be restrained from playing with the other children when she heard their voices on the street, and for the last two or three months she has been playing about the streets, as lively as the best of them.

CASE OF MOLAR PREGNANCY COMPLICATED WITH PUERPERAL URÆMIA.

BY E. H. WILLIAMS, M.D., C.M., L.R.C.P., LOND.
(Toronto General Hospital.)

N. A., æt. 21, admitted to hospital Oct. 4th, said to be suffering from rheumatism. It was soon ascertained that she was pregnant about three months. A dark, offensive discharge was observed from the vagina. A bath was carefully taken by patient, after which she soon began to flow, somewhat profusely. As she denied anything like labour pains, it was thought the progress might be stopped, and accordingly (the os being only slightly dilated), perfect quiet was enjoined, and full doses of black haw, opium and cannabis indica, administered. It soon became evident, however, that this was of no avail, and a plug, of the kite-tail form was introduced, and replaced by another in 6 hours, which second remained in 8 hours, when the os was found dilated. During this time ergot was given by the mouth, but provoked vomiting after a time. The uterus was then easily emptied of a mass having a feel of placenta, but which proved to be a much hypertrophied decidua containing an imperfectly formed amnion, with a number of black clots beneath it. No trace of what could be called an ovum could be found among the clots or anywhere in the mass. Several semi-organized clots were taken out of the uterus, and ½ a drachm of ergot (F. Ext.) administered hypodermically (into the gluteus). All went well for a while, but that night the patient was unable to sleep, so that small doses of pot. brom. and tr. lupuli. were given. About 2 a.m., however, was called up, and found patient very restless and irritable, trying to get out of bed.

A catheter was used, and about 2 ounces of urine drawn off, which was found to contain about ⅓ albumen, *sp. gr.* 1011. Pulse 145, and rather feeble; temperature 102⅗. Hot fomentations were applied over the loins, and more blankets put over her, and a mixture of liq. amm. acet., spts. æth. nit. and fl. ext. jaborandi given. Hot water bottles were applied to feet. Diarrhœa had by this time set in, and was not stopped. For a while perspiration was free, and in the morning she seemed better as regards pulse and temperature, but in a state of semi-delirium, which seemed to lessen towards noon, when she became suddenly comatose, with dilated pupils, stertorous breathing,

etc., and died in a very short time. There was no sign of a convulsion from beginning to end, and from the beginning of threatening symptoms until death (about 12 hours) there were about 7 oz. of urine secreted. She admitted having taken oil of juniper on one occasion to procure abortion. Had given birth to a healthy child 3 years before.

A *P. M. Examination* was made by Dr. Teskey, and the following conditions found: The *heart* weighed 11 oz., and the valves were healthy.

Lungs, œdematous and congested.

Liver (4 lbs, 8½ oz.) congested, edges thickened, and a tendency to fatty degeneration.

Spleen (16½ oz.) congested, soft and friable.

Uterus (8½ oz.)—no signs of peritoneal or cellular inflammation around uterus. Ovaries and corpus luteum normal. The os uteri was scarcely dilated, but slightly ecchymosed on its inner surface. A few small clots were found on the inner surface of the body of the uterus.

Kidneys,—capsules adherent in places, tissues markedly congested, light and dark streaks running from the centre peripherally. A small abscess was found in the right kidney near the pelvis.

The *cranium*. Vessels of dura mater congested, and a milky appearance of the pia mater at the upper part, the whole brain presented a "wet" appearance.

Considerable serum was found in the subarachnoid space, especially at the base, and also in the lateral ventricles, of which the lining membrane was opaque. The choroid plexuses were much congested. No emboli could be found in the cerebral vessels.

A microscopical examination of the kidneys was also made by Dr. Teskey.

Pathological changes were most marked in the cells of the convoluted tubules. These were found enlarged, angular, and mostly separated from the walls so that many had fallen out in the process of mounting, leaving the tubules naked. The cell contents were markedly granular, the nuclei not readily seen, and the lumen of the tubes small, irregular, and choked by broken epithelial cells in many places, especially near the boundary area. The glomeruli were somewhat enlarged and hypernucleated with thickening of Bowman's capsule. The inter-tubular tissue was also increased in thickness and nucleation. No marked changes were found in the tubules of the pyramids.

THE NEW LOCAL ANÆSTHETIC, HYDROCHLORATE OF COCAINE—EXPERIMENTS WITH CAFFEINE.

BY R. A. REEVE, B.A., M.D.

Senior Ophthalmic and Aural Surgeon, Toronto General Hospital—President, Toronto Medical Society, etc.

It is not surprising that the virtues of a drug which is at once absolutely non-irritant and equally anæsthetic to the urethra and conjunctiva, the cornea and drum-head, and the mucous membranes of the larynx, naso-pharynx, vagina, etc., should be promptly and widely tested and heralded. The various indications it fulfils will be so apparent as hardly to need specifying. The following cases illustrate in part its potency, and one is cited, not without interest, in which it proved useless. The solution used was of four per cent. strength, the two per cent. having been found too weak, as a rule, for operations upon the eye.

CASE 1.—J. A. Toronto General Hospital, Iridectomy, Nov. 11th. Four applications in fifteen minutes; operation begun five minutes after the last; no pain,—"just felt the doctor was doing something."

CASE 2.—J. T. T. Sclerotomy for secondary glaucoma, —drug useless. Six instillations (of several drops) in twenty-five minutes; operation attempted five minutes later, but patient not tolerating the use of knife or forceps, chloroform had to be used. The patient was a very nervous subject, and there was possibly idiosyncrasy in addition to evident hyperæsthesia.

CASE 3.—Mrs. McC. *Operation for secondary cataract:* solution applied three times in ten minutes; discission ten minutes later. The patient, a nervous lady, said she "felt not a bit of pain."

CASE 4.—Mrs. T. *Mucocele; Bowman's operation:* three applications on punctum and inwards; canaliculus slit as far as caruncle without pain, and into sac with but little; pupil moderately dilated, but contracting to light and on accommodation.

CASE 5.—Mrs. M. *Iridectomy for inflammatory glaucoma:* five instillations upon upper margin of cornea in fifteen minutes; five minutes later, section at sclero-corneal junction not felt; solution dropped upon wound holding knuckle of iris; two or three minutes later segment of iris excised. The patient, a delicate nervous lady, said "she only felt the operation a little."

CASE 6.—M. C. æt. 3½ years: *Staphyloma of cornea:* Fifteen minutes after a single instillation, the cornea was incised, without complaint.

CASE 7.—Mrs. C. The galvano-cautery was applied to several points on the septum and turbinates after the use of the solution, without other discomfort than fleeting neuralgia of superior dental nerves.

CASE 8.—Ulceration of larynx. A two per cent. solution gave marked relief of irritability.

CASE 9. — *Inflammation of auditory meatus.* Solution dropped into ear; tenderness and pain sensibly relieved—"a sort of numbness."

CASE 10.—E. L., Toronto General Hospital. *Iridectomy.* Five applications in forty minutes; operation ten minutes after the last; section of cornea not felt; the seizure and excision of iris gave some pain.

CASE 11.—F. G. H. *Pterygium.* Four applications; abscission and suturing practically painless.

CASE 12.—N. McL. *Strabismus.* Four instillations in fifteen minutes; tenotomy five minutes later; moderate pain caused by traction upon muscle with hook, but none in cutting tendon; pupil not dilated in thirty minutes.

Under cocaine, extraction of cataract is not more painful than iridectomy; and more frequent droppings or stronger solutions than the four per cent. may be fonnd to anæsthetize the iris—a safer plan apparently than injecting into anterior chamber. Cocaine may be used to prevent (or mitigate) the after pain of operations in various parts and lessen risk of secondary inflammation. It will doubtless prove valuable for relief of pain, photophobia and spasm of orbicularis from corneal irritation, as well as of reflex ills elsewhere, of kindred origin. The writer has been disappointed in not finding an 8 or 10 per cent. solution of the alkaloid itself in oleic acid anæsthetic to the skin; but the aqueous solution of the salt can be utilized hypodermically for local anæsthesia, to some extent at least. In solution or unguents of various strengths, it should allay the pain of burns, &c., and the itching in some skin diseases.

EXPERIMENTS WITH CAFFEINE.—Influenced by the alleged identity of the general physiological, if not therapeutical, effects of caffeine and cocaine, the writer was led to test the former, hoping that it also might prove to possess local anæsthetic properties; but a four per cent. solution failed to appreciably lessen the sensitiveness of his own conjunctiva. Bearing in mind that caffeine is only one-sixth of the strength of cocaine as regards systemic effects, a much stronger solution of caffeine* was next tried, namely; twelve per cent. on the patient, case 1, in whom the anæsthetic properties of cocaine (4 per cent. sol.) had been quite decided; but the conjunctiva remained sensitive, and grasping it with forceps caused pain. This would seem to shew that caffeine is not a local anæsthetic; a fact to be regretted, because it can be had pure and cheap, and the supply is unfailing, while it would seem good coca leaves are seldom imported.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—To save other medical men from sharing the fate of Dr. Rabbeth, of the Royal Free Hospital, London, who recently lost his life by sucking through a tube the secretions from the trachea of a diphtheritic patient upon whom he had performed tracheotomy, I communicate to you the following. A few weeks ago I performed tracheotomy on a little girl about eight years of age, for relief from the consequences of acute laryngitis. Three days after the operation an attack of broncho-pneumonia supervened, and the secretions became so copious and were at the same time so tenacious, that it was found impossible to keep the tracheotomy tubes clear, and to prevent suffocation in a terrible paroxysm, I was obliged to withdraw the tubes entirely and trust to the larger opening thus secured for respiration and the escape of the secretions. After the removal of the tubes respiration continued very imperfect and labored, owing to a large quantity of mucus still remaining in the trachea, and for the extrusion of which the patient could not muster sufficient expulsive force. At this juncture I went to my office, a short distance, for an India-rubber bulb and tube, with which to suck out the accumulation, leaving my partner, Dr. Henderson, and a couple of students with the patient. During my absence, another violent paroxysm of suffocation came on, and Dr. H., by means of a rubber tube, sucked out some of the mucus, and one of

*Though bought from a reliable house it may prove on analysis to be impure.

the students did the same thing. Nothing more was thought of this until about three days after, when Dr. H. complained of a sore throat, the parts being highly inflamed, dark in color, and covered with diphtheritic patches. He continued very ill for eight days, and some part of the time fears were entertained as to the result. The student, a day or two later, was taken in a similar manner, though not so severely, and was a week sick. As the rubber bulb would not draw sufficiently to be effective, another means was thought of, as it was evident that the expulsion of the secretions would for a long time require external aid.

The aspirator came next to our minds, and on trying it we found that we had all we could desire. The needle was removed and a small rubber tube, about eighteen inches in length, was attached. Whenever the secretions collected so as to be troublesome, the tube was inserted through the wound into the trachea, the bottle exhausted, the stop-cock turned so as to open the entrance, and powerful and effectual suction was at once accomplished. As soon as the bottle became filled with air, it was again exhausted, the stop-cocks shut, and the apparatus thus prepared kept at hand ready for use. For several days and nights this contrivance was kept in almost constant demand, and most undoubtedly saved the patient's life.

This is not worthy of the appellation of a "new discovery," but it certainly is a new application of a most useful instrument, and one that should never be forgotten for cases requiring this kind of treatment. Valuable lives have been sacrificed by the act of sucking secretions out of diseased throats; and notwithstanding all the cautions against the practice given by our best authors, ambitious and impulsive young practitioners will occasionally risk their lives by performing it. In a late number of the *Brit. Med. Jour.* there is a cut showing the construction of an instrument for use in such cases, consisting of two rubber tubes connected by a hollow glass bulb for receiving the matter as it is sucked out, and to one end is a mouth-piece attached for the operator. But all this is useless, as long as we admit the germ theory of contagion; the air from the diseased parts, no more than the secretions, should pass into the mouth and throat of another. With the aspirator used as I have pointed out, all danger of contagion is avoided; by the use of a large bottle a more powerful suction can be exercised than can be by the mouth; and by regulating the stop-cock, it can be made to act powerfully or feebly, can be suddenly started and stopped, and the whole apparatus kept ready for instant use. Better than turning the stop-cock every time one wishes it to act, while sucking out collections of mucus, is to compress the tube between the thumb and finger with which it is held; for the suddenness with which it can thus be made to act renders it far more efficient in picking up partially hardened and isolated portions. The aspirator, then, should be one of the instruments of the laryngotomist, and of every one who attends cases in which matter has to be removed from the larynx and windpipe by external force.

Yours truly,

THOS. R. DUPUIS.

Kingston, Nov. 17, 1884.

[A writer in the *London Lancet*, Nov. 8th, 1884, after claiming to have used the aspirator in this way during the past nine years alludes to the defects in the apparatus owing to the air being drawn into the trachea by the side of the suction tube, and recommends the addition of a piece of wash-leather about 6 x 6 to the tube. A piece of vulcanite tube is passed through a small hole in the centre of the wash-leather, which is tied firmly. The suction tube is then passed through this and into the trachea. The wash-leather is moistened and spread over the neck of the patient, and effectually prevents the entrance of air alongside the tube. ED. LANCET.]

PROFESSIONAL ADVERTISING.

To the Editor of the CANADA LANCET.

SIR,—Under the above caption a recent number of the LANCET refers to an ex-president of the Nova Scotia Medical Society who occupies half a page in announcing his "Private Infirmary," in Belcher's Farmer's Almanac. It also states that, "this same gentleman issued a circular on the eve of his departure for Europe in which he modestly states that he expects to visit the larger special hospitals of England, France and Germany, and to bring back 'increased stores of knowledge' together with 'new surgical apparatus.'" And now the town of Amherst, N.S., scores another on this count. A medical man who practiced in a village in that section of country and achieved considera-

ble of a certain species of notoriety, finding it desirable to remove, also went to Europe, and in a short space of time comet-like returned with an immense appendage composed of a large number of the letters of the alphabet. He is now astounding the public and the profession by his announcements of "increased stores of knowledge," and the possession of a marvellous 'new surgical apparatus,' costing him "a thousand dollars, and which is unknown to the surgeons of Canada or the United States." By means of this 'instrument' he "will be enabled to successfully carry and apply infallible remedies directly to all or any of the internal organs of the human body."

Apropos of the above in the *Maritime Sentinel* newspaper there recently appeared the following: "Dr. H— successfully removed from the neck of Miss Marney a tumor of three year's standing. The difficulty of removing this tumor was from its being situated among the large blood vessels of the neck." The profession will doubtless be surprised at the surgical and anatomical knowledge possessed by our newspaper reporters, and their simplicity of description for popular reading and edification. The sources from which such articles usually originate are sufficiently apparent and the above is a good illustration. It will not be less surprising when it is stated having been positively ascertained from several practitioners who had been consulted, that the tumor was a very small fibrous growth situated just beneath the skin, about the middle, and below the margin of the left inferior maxilla, and which was "successfully removed" by making an incision at right angles to the jaw bone, leaving a cicatrix more disfiguring than the tumor, which was its greatest discomfort. This matter was allowed to pass unnoticed although perhaps by coincidence an article appeared in the following number of the *Lancet* dealing in general terms with such subjects as the above, and which would have been sufficient to deter any but the most unscrupulous and adventurous from the repetition of such acts.

Nevertheless in a more recent publication of the *Maritime Sentinel*, occurred the subjoined paragraph:—"Dr. H.— successfully removed from the mouth of Miss Austin of River Philip a tumor of four months' standing which had grown rapidly until it was the size of a hen's egg. Miss Austin had just returned from the hospital at Halifax where they declined to operate. She is doing well." Now this second flagrant violation of the code following so closely upon the other, cannot be permitted to pass, and after careful enquiry into the case, and observing correspondence in the public prints relating to the matter, the following references will place the subject in its proper light. A communication from a medical man to one of the papers calling attention to the repetition of such unprofessional conduct, elicited an answer from an anonymous correspondent, and which was refused publication on account of its "style and inuendoes," and it ultimately transpired that the "reporter" of the "surgical operation" and the anonymous correspondent, was a proxy, prompted and dictated to by the ubiquitous surgeon in question in order to shield himself from the responsibilities of his acts. By reference to the books of the hospital it cannot be found that such a patient ever applied for treatment, and careful enquiry from undoubtedly reliable sources goes to prove that the tumor was a ranula and the "successful removal" consisted in the introduction of the point of the lancet! And now applying the principle of "*similia similibus curantur*," we have decided to introduce the point of the *Canada Lancet* into this benign (?) surgical neoplasm. You have well written it, Mr. Editor, that "our confreres down by the sea are not to be outdone in the matter of advertising."

Yours truly,

A HALIFAX SURGEON.

Halifax, N.S., Nov. 14th, 1884.

[Professional, or rather unprofessional, advertising seems to be a growing evil, and is not confined to any particular Province or locallty. One of our city papers recently contained a most glowing account, in black letter heading, of "A Terrible Operation," "A man's tongue cut out to save him from an awful death," performed by one of our own colleagues of the Toronto Hospital staff. When such "things are done in the green tree, what shall be done in the dry"—ED. LANCET.]

Reports of Societies.

CHICAGO MEDICAL SOCIETY.

Reported for the Lancet.

At the regular semi-monthly meeting of this society, Dr. E. Andrews presented a report of the

following cases: Two cases of gastrotomy, two cases of excision of the rectum. Remarks on lithotomy, and exhibited a new instrument for varicocele.

Dr. S. V. Clevenger read an elaborate treatise under the head of "Political Abuse of the Insane."

Drs. B. and J. Bettman read interesting papers on hydrochlorate of cocaine, illustrating its use in ophthalmic and nasal surgery. The physiological and therapeutical effects of the alkaloid may be tabulated as follows:

(1) Hydrochlorate of cocaine is a powerful local anæsthetic, not penetrating in nature, rapid in its effects, which however are only temporary.

(2) It is a mydriatic, the effect of which is regulated by the strength of the solution.

(3) It produces paralysis of the ciliary muscle, the near point receding from the eye—distant vision is not influenced.

(4) By virtue of its benumbing powers it may be classified as an anodyne.

The following cases were cited, where the drug was used to produce local anæsthesia: Operation for dilatation of the nasal duct; removal of a piece of steel from the cornea, the same having been embedded for two days; operation for cataract; cauterization of the inferior turbinated bones; and to relieve the pain in otitis media acuta purulenta, in each of which it gave the most gratifying results.

The following report was presented by the Committee on "National Sanitation," and adopted. It is really written in the interest of the National Board of Health of the U.S., and was first suggested by Dr. Montgomery, the Secretary of the Society:

The committee appointed at the meeting of this society, Sept. 15th, 1884, to consider and report upon a series of resolutions presented by Dr. L. H. Montgomery, having reference to national sanitary matters, respectfully report the following That in the judgment of this Society, the sanitary interest of the United States demands the establishment of a permanent national health authority, which shall have for its main functions the detection of pestilential and epidemic diseases, and the enforcement where necessary of sanitary regulations tending to prevent, abate, or suppress them. That a committee of three be appointed by this Society, to collate facts tending to show the usefulness and necessity of a national sanitary organization, and to compile the same in such form as may be available for disseminating information upon, and creating an interest in national sanitary legislation. That the said committee be empowered and instructed to urge the importance of national legislation upon the attention of the congressional delegation from Illinois, and fittingly to present the subject to representatives of the people in both houses of Congress. All of which is respectfully submitted.

O. C. DeWolf, *Chairman.*

Selected Articles.

EXOPHTHALMIC GOITRE—CATARRHAL JAUNDICE—LYMPHADENOMA—CATARRHAL NEPHRITIS — INTERSTITIAL NEPHRITIS — SPECIFIC DISEASE OF THE SPINAL CORD.

CLINIC BY PROF. BARTHOLOW.

EXOPHTHALMIC GOITRE.

This case was also before the class a short time ago. It is a case of exophthalmic goitre, presenting the usual quarternary of symptoms, although the fourth was not so distinct as the others. There are present: protrusion of the eyes, enlargement of the thyroid, which, in this case, however, is not as great as it often is, and rapid action of the heart. The fourth symptom of this affection—dilatation of the vessels—was not so well marked. In severe cases the thyroid gland pulsates with the force of an aneurism. In addition to these symptoms there is, as a rule, marked anæmia. This was a prominent feature of this case.

The treatment which she received, and which acts very favorably in cases of even severe exophthalmic goitre, consisted in the administration of the following pill:—

℞. Extracti ergotæ,
Ferri sulphatis, *aa* gr. xxx
Strychnine sulph., gr. ss. M.
Ft. pil. No. xxx.
Sig.—One three times a day.

There has already occurred a marked improvement, and I have no doubt that by a persistence in this treatment the symptoms will gradually subside.

I also pointed out, when this patient was first before you, that in the treatment of uncomplicated cases of exophthalmic goitre there is no remedy so successful as galvanization of the cervical sympathetic. I have repeatedly seen symptoms of a violent character disappear under the use of galvanism,

the positive electrode being applied in the fossa, behind the angle of the jaw, and the negative on the epigastrium. A current of from ten to thirty cells is used, according to the condition of the patient and the amount of reaction. The stabile galvanic current is the proper one. The applications should be made daily for ten minutes at a time. This will tone up the sympathetic, which is the seat of the disorder; it will moderate the action of the heart, contract the dilated vessels and diminish the size of the thyroid. I am particular in saying that the constant galvanic current will cure uncomplicated cases of exophthalmic goitre, and I must insist on that proposition. There are many cases in which complications exist, the most usual being in the heart and great vessels. Such lesions, being permanent, cannot be removed by such a remedy. On the other hand, there are certain cases which are entirely uncomplicated, in which there is purely a functional derangement of the sympathetic system. That functional derangement is entirely removed by galvanic stimulation.

We must, however, not lose sight of the fact that the treatment is not directed solely to the ganglia of the sympathetic, for if one electrode be placed behind the angle of the jaw and the other on the epigastrium, there are within the circuit not only the cervical sympathetic, but the pneumogastric, the descendens noni and the cardiac branches of the sympathetic.

CATARRHAL JAUNDICE.

In this case the diagnosis is comparatively easily made. Looking at this patient, you see that he is jaundiced; the conjunctiva is very yellow, and the skin has a distinctly yellow tinge. Let us now turn to the history, for the history of every case needs to be very carefully investigated; and in a case like the present, the history may of itself furnish the data for a diagnosis.

Three weeks ago the patient began to feel distress in the epigastrium. Taking but a small quantity of food into the stomach sufficed to bring on a choking sensation, and caused him to feel filled up. There has been more or less nausea and occasional attacks of vomiting, and this was especially marked during the past week, when he vomited six times. The tongue is coated with a thick, yellowish fur, which is especially marked on the left side. The passages are whitish, and entirely wanting in their normal color. I inquired whether the stools were mal-odorous, for, as you know, bile prevents the decomposition of the food, and when the bile is wanting, the food may undergo ordinary putrefactive decomposition, and the stools in consequence, may be very offensive. The bile evidently does not flow into the intestine, and we see that it passed backward into the blood. It being eliminated by the kidneys, as shown by the appearance of the urine.

How much pressure is required in front to make the bile pass back into the blood? It has been ascertained by actual observation, that if there is catarrh of one-half an inch of the ductus communis choledochus, with swelling of the mucous membrane at its termination at the duodenum, this will produce sufficient obstruction to prevent the flow of bile into the intestine, and cause it to pass back into the blood.

There are supposed to be two forms of jaundice, hepatogenous and hematogenous. In the former the jaundice is due to reabsorption of the bile; in the latter to the disorganization of the red blood globules.

In the present case we have a history of gastro-intestinal trouble followed by jaundice. We know that these attacks of biliary disturbance are exceedingly common in malarious districts. This man has been living in a malarious section of the country until the past three months. Malarial poisoning may cause jaundice in two ways; first, by producing a catarrh of the ducts, and second, by its action on the hepatic cells. We know that in chronic malarial toxæmia, the hepatic cells are crowded with bile pigment. It is probable that the poison which causes malaria acts directly on the hepatic cells, increasing the formation of pigment, and favoring its deposit in the body. In this case there is a distinct malarial element, which has much to do with the disturbance. This has a practical bearing, for these cases, although they may present no obvious malarial trouble, are not readily cured without the administration of an antiperiodic.

Taking these things into account, we come to the conclusion that this is a case of catarrhal jaundice, and that there is also a malarial element.

Such is the therapeutical diagnosis. What are the most useful remedies? The phosphate of sodium is the most efficient remedy for causing the catarrhal process to disappear, and to favor the flow of the bile into the intestine. It will be given in drachm doses three times a day. In this case it will be advantageous to combine with it the arseniate of soda in the dose of $\frac{1}{10}$ of a grain three times a day. We must not disregard the malarial impression. I will direct the salicylate of cinchonidine five grains three times a day. This is a most efficient substitute for sulphate of quinine in ordinary malarial attacks.

LYMPHADENOMA.

At first sight this case may not seem of much importance, but in reality it is of great importance. There is, as you see, a bunch of enlarged glands on each side of the neck. The axillary glands are also enlarged, and I also find that the area of splenic dulness is increased.

That disease characterized by progressive enlargement of the lymphatic glands, by splenic changes and profound anæmia, is known as lym-

phadenoma. Such cases are progressive, going from bad to worse, and, ultimately, if not properly treated, have but one ending. Is this a case of that kind? At this stage it is almost impossible to say. It may be enlargement of the glands due to strumous disease. I am inclined, for two reasons, to doubt this. In the first place, there is no evidence of strumous disease in any other part of the body, and, in the next place, there is enlargement of the spleen; and the spleen is not only enlarged, but it is firm. Then the characteristic progressive anæmia is not wanting.

Lymphadenoma is a constitutional disease. The gland elements undergo the changes known as hyperplasia and hypertrophy— enlargement of existing elements and formation of new elements.

Various measures have been proposed for the relief of this disorder. It has been suggested that the hypertrophy of the glandular system may be arrested by the extirpation of those first affected. It has been found that if the glands be removed early, the disease being limited to one group, we can prevent its spread beyond the glands first involved, showing that there is something generated in the first set of glands which undergoes multiplication and which gradually affects the glands of the body generally.

The treatment must be both systemic and local, the latter being the most important. Internally, probably more good has been done by phosphorus than by any other remedy. It is best given in $\frac{1}{100}$ grain doses, dissolved in a drachm of cod-liver oil, three times a day. Good effects have also followed the use of the syrup of the iodide of iron and manganese. These may be given in combination with the phosphorus. I have found ergot to do great good in a case now in my hands.

As I have said, the most important part of the treatment is the local treatment. The best local remedy is injection of arsenic into the affected glands. The amount of arsenic said to have been used in some cases is almost incredible, as much as thirty to sixty drops of Fowler's solution having been injected at a time. In practicing the injection, ether spray or a piece of lint moistened with chloroform, is applied, to benumb the skin. The hypodermic needle is then inserted and a few drops of Fowler's solution thrown in. The injections should be practiced on alternate days. Various other things have been used locally. Injection of iodine has been employed, but it is much more painful and less efficacious than arsenic.

What is to be done for the enlarged spleen? Our German colleagues are in the habit of injecting arsenic into the spleen. They do this with apparent impunity and with great apparent good. I might enumerate many other remedies but the most important are phosphorus with cod-liver oil, and the injection of arsenic.

PARENCHYMATOUS NEPHRITIS, PROBABLY SPECIFIC.

The interesting cases now presented have such characteristic symptoms that you can almost make the diagnosis at a glance. The first patient is a woman, 47 years of age. The arteries are atheromatous. The tension of the vessels is very high. This is due not only to the deposit of calcareous matter, but also to hypertrophic thickening of the muscular layer in the walls of the vessels. Observe the expression of the face. The lips are bluish and the face is more or less swollen, and there is some difficulty in breathing. Examination of the heart shows that there is more or less atheromatous degeneration of its valves. Notwithstanding the fact that there is no distinct lesion of the lungs, she has at all times difficult breathing. Thi is not an ordinary case of asthma. There is also a peculiar cough. There is no reason to suspect hepatic derangement.

Examining the urine, we find that it contains albumen. The specific gravity of the urine is low, the amount of solids excreted small, and the quantity diminished. There is general œdema. There are uræmic asthma, and also headache and other symptoms indicating uræmia. Such is the morbid complexus. The patient has a well-marked eruption on the left chest and mamma. This has a peculiar appearance, and makes me suspect specific disease. There are also cicatrices about the mouth, which have the appearance of having been healed under the action of iodide of potassium. In other words, the kidney lesion is probably of specific origin.

Such being the conclusion, the treatment necessarily follows. As, in all probability, there has been no thorough specific treatment, we shall begin with the green iodide of mercury, in one-eighth of a grain dose, four times a day. If this acts on the bowels, a little opium will be combined with it.

Something must be done to relieve the suffering organ by derivation, either by purgatives or diaphoretics. We shall act upon the bowel in the present instance with compound jalap powder, in drachm doses, every morning. This has an effect, by reflex action, to increase the flow of urine. If this is not enough, pilocarpin, in sufficient amount to act energetically on the skin, will then be given.

INTERSTITIAL NEPHRITIS.

Here is another disease of the same kind, but of a different origin. This woman has not the expression of ill health seen in the other. She is not so pale, notwithstanding the fact that her urine contains a larger amount of albumen. The first woman has been made prematurely old by the specific trouble and the remedies used to relieve it. This patient has general œdema, which, however, is not considerable. The feet are swollen at night and the face is puffy. There is no change in the heart

or vessels, and apparently no alteration in the liver. This is a case of simple albuminuria, but, in order to say what its real nature is, a careful examination of the urinary secretion and a microscopical examination of its sediment will be required. This we have not yet had time to do. The probability is that, as the urine is of low specific gravity, and not diminished in amount, it is a case of interstitial nephritis, and not merely a croupous condition. It is essentially chronic in its course.

As regards the remedies, I shall apply here two which I have found very successful, and which I have repeatedly recommended. These are nitro-glycerine and the chloride of gold and sodium. The latter has the property of checking hyperplasia of connective tissue. The nitro-glycerine has been found by experiment to diminish decidedly the amount of albumen; it lessens congestion and limits the change going on in the kidney. Although nitro-glycerine causes dilatation of the peripheral vessels, it is still true that it relieves congestion. The area of dilated vessels in the kidneys is small as compared with the capillaries of the body, so that the mechanical result of dilatation of the arteries in general must be to relieve congestion of important organs.

This patient will begin with one drop of the centessimal solution of nitro-glycerine, three times a day, and one-twentieth of a grain of chloride of gold and sodium in combination with a simple bitter, as extract of nux vomica. Under this treatment decided improvement should be observed.

SPECIFIC DISEASE OF THE SPINAL CORD.

Here is another interesting case, but, as my time has almost expired, I shall have to go over it very rapidly. You notice the p culiar manner in which he stands when his eyes are closed. It is with difficulty that he can cross one leg over the other. The patellar reflex on the right side is well marked; on the left it is not quite so distinct. He has some pain in the calves of the legs. These first appeared ten weeks ago. He has never had any trouble in vision, and has never had double vision. The trouble in walking has developed within a year. He has nocturnal emissions. There is lessened sensation in the bottoms of the feet.

Now what is the explanation of the rapid development of this case, for these are in large part the symptoms of posterior spinal sclerosis? It has not been evolved in the ordinary manner. The symptoms have developed in an irregular way within the past twelve months. There must be some explanation of the rapid evolution of these symptoms and of their irregularity. This, I think, we find in the condition of the tongue. You see the characteristic mucous patches. In other words, this is a case of specific disease of the spinal cord.

As the spinal cord is in danger, it will be well to use mercurial inunctions in combination with the internal administration of the green iodide, one-sixth of a grain of which, with one-fourth of a grain of the extract of belladonna, will be given three times a day. A little opium will be added if it is necessary. One drachm of mercurial ointment will be rubbed into the groins and inner side of the thighs every day, attention being paid to the condition of the mouth, as it is important to avoid salivation, for these cases do better if the mercurial impression is not carried so far.—*Col. and Clin. Record.*

ABDOMINAL SECTION IN DISEASE OF THE UTERUS.

Abstract of a lecture delivered at the Jefferson Medical College Hospital, September 15, 1884 by Lawson Tait F.R.C.S.

OVARIAN TUMOR.

Here is a patient who, as far as I can see, is the victim of a disease which is very common with us and I suppose as common with you. At first sight, it looks like an ovarian tumor. The first thing which attracts my attention is a scar from a puncture, and here I see the remains of another puncture of an older date. I next notice the uniform shape of this abdomen. There is a symmetrical uniformity about this abdomen which is suspicious. When you see a perfectly uniform enlargement of the abdomen, begin by suspecting that it is not due to an ovarian tumor. The chances in such a case are greatly in favor of one of three things. In the first place, pregnancy, which you must always eliminate; in the second place, a small tumor with malignant growth and ascitic effusion, which is the most likely of the three; and, in the third place, the presence of a parovarian tumor. I next place my hand on the tumor,—and here let me give a caution. When you are dealing with abdominal disease either for the purpose of diagnosis or treatment, you cannot be too gentle in your manipulations. If at all rough in your manipulations, the first thing you do is to frighten the patient and obscure the diagnosis. The abominal muscles will be contracted, and you will not be able to learn a great many things which it is desirable that you should learn. If in treating abdominal disease you handle the parts roughly, you run a risk of doing harm. I touch the abdomen gently and I have already learned a good many things. I learn, in the first place, that this certainly is not pregnancy, although I knew that before. I learn, in the second place, that it is not a parovarian tumor. I learn, in the third place, that it is probably a small tumor with a large amount of ascitic effusion. I feel in the lower part of the abdomen a semi-solid mass, and above this a mass which is not solid. Our business is to

determine what relation the mass not solid bears to the mass which is solid. Above, we obtain on percussion the resonance of the intestine. There is a matter here which obscures the diagnosis. That is the fact she has been tapped. I get an intestinal note above, and there is evident fluctuation, but from these two factors I cannot positively determine which one of the two conditions is present, and it is a rather important thing to know which we have before giving advice.

The conditions to which we refer are the following: This may be a large cyst which has been emptied by tapping, or it may be merely ascitic fluid. If it is a large cyst which has been partially emptied, or which having been emptied, has become partially refilled, it is a case of multicystic cystoma, which can be dealt with in a satisfactory manner. In the second place, it may be a small cyst covered with a large effusion of ascitic fluid. If this be the case, it will be necessary to engage in the discussion of a number of points before making up our mind. I have looked at the patient's face but find nothing there to guide me. I have examined the pelvis, but I find nothing but negative indications. The uterus is small and tolerably free. On the left side there is a small tumor which may be one of two things, either the left ovary in a state of incipient enlargement, or a small mass of papilloma. This may be a single ovarian tumor and the condition here may be the result of malignant proliferation on the outside of the tumor, or on the parietal peritoneum, or the peritoneal coat of the viscera. It is important to know which of these is the more likely. With a half-full abdomen like this, one cannot pretend to to give an opinion. The fluid has been removed and reaccumulation is taking place. Although it is impossible to give a positive opinon, I have a suspicion that the fluid which was removed was not removed from a cyst. There is a small tumor in the lower part of the abdomen, and I think that the fluid which was removed was ascitic and that there is here a condition of papilloma. Suppose it is impossible to come to an exact conclusion, what ought to be done? Open the abdomen in either case; for, unless you are absolutely certain that the disease is incurable, it is, in my judgement, a surgical crime to allow a patient to go to the grave with an abdominal tumor, without an effort being made to save her. This should be done even when papilloma, which is a most unfavorable condition, is suspected.

As soon as an ovarian tumor is recognized, you should refrain altogether from tapping, and immediately remove the tumor. The patient whom we have had before us has been tapped. I do not know whether the fluid removed was ascitic or from a large cyst. My suspicion is, as I have already said, that the fluid was ascitic. At this point some critics might ask "What do you make of those cases in which tapping was done over and over under the old practice, and sometimes under the new, for some patients will not submit to the radical operation?" In regard to the latter point, there is no difficulty with that now. During the last five or six years I have not had a patient come to me with an ovarian tumor, who has refused to have it removed. I can assure her that the chances are 98 out of 100 that she will get well, no matter what the age, no matter what the appearance of the tumor, and no matter what complication may be present, provided it is not malignant disease and that there has been no previous tapping.

Suppose you get an ovarian tumor, when should it be removed? The arguments are all in favor of early operation. The patient is not distressed with the suffering entailed by carrying around a large mass; she is not subjected to the likelihood of the development of papilloma which we suspect in this case; she is not subjected to the anxiety and worry, especially if unmarried, which her appearance will always cause, and the incision will be shorter than when the abdomen is large. The mortality of early opertions is almost *nil*. If the tumor be removed before adhesions form or other complications occur, I believe that the mortality would be absolutely *nil*. My own experience leads me to believe that if the practice were uniform all over the world of removing ovarian tumors as soon as discovered, the mortality would not be one per cent. Suppose that we are certain that this patient was suffering from papilloma, that the disease of which we are so much afraid was developing around the tumor; even if I were certain that such was the case, and I were responsible for the treatment of this patient, I should proceed to the removal of the tumor. The reason for that is a very curious one, and one which I cannot pretend to explain, but the facts of which I am quite certain. I cannot say, without referring to my class-books, how many ovarian tumors I have removed, but in a considerable percentage both of parovarian and ovarian tumors, and also cases of myoma, and also in cases where there has been no tumor at all, I have opened the abdomen, sometimes knowing what I should find and at other times not knowing, and have found this curious velvety, warty condition of the peritoneum. One of the most extraordinary cases which I have ever met with, was one sent to me by Mr. Oliver Pemberton, of Birmingham, whose name is probably familiar to many of you. In this case there was enlargement of the abdomen, supposed by several who had examined her to be a parovarian tumor. As soon as I placed my hands upon the abdomen I was certain there was no tumor, but simply an enormous effusion of ascitic fluid. In such csaes as this I never tap, I always make an opening in the abdominal wall large enough to admit the introduc-

tion of two fingers, and obtain an intelligent idea of the condition of the abdomen, which cannot be obtained by gazing at the fluid falling from the end of a canula. There is no more danger in this than in tapping. So far as my own practice is concerned, tapping is absolutely discarded. In the case to which I have referred, I made the abdominal opening, and slipped in two fingers, and at once found that I had to deal with universal papilloma of the peritoneum. I inserted a drainage-tube, and allowed it to remain two or three weeks, and completely cured the patient. She is now in robust health some fours years after the operation. In another case, in a woman fifty-seven years of age, I removed a large ovarian tumor. Large masses of papilloma were also found. Two of these, each being larger than the fist, could not be removed, and after the operation could be distinctly felt through the abdominal wall. She is now sixty-five years old in good health, and the tumors have disappeared. It is certain there are two kinds of papilloma, one of which is malignant, and which will kill the patient in a few weeks or months, and another kind which is not malignant, and can be cured by removing the tumor or by opening and draining the cavity. I have submitted pieces of papilloma, some of which were obtained from cases which had been cured, while others had come from cases rapidly fatal, to the most experienced microscopists, and they have been unable to detect any difference between the two varieties. This curious condition, presenting as it does such extremely different features, so far as results are concerned, offers a very favorable field for careful research by pathologists. In this case, even if I knew positively that there was present an ovarian tumor com licated with ascitic fluid and large papilloma, I should still urge that if it is possible to remove the tumor, it should be done, for there is a chance that the patient will be cured.

REMOVAL OF THE UTERINE APPENDAGES.

The next case is one which would involve a great deal of talking, and one of which I cannot speak anything like exactly, for that would involve an intimate knowledge of the past history of the patient. For the purposes of instruction however, I may assume what is doubtless the fact, that this girl's sufferings are real and intense, and that everything short of surgical interference has been employed. I might with advantage talk of a case which I treated in the state of New York, in which the the condition was to some extent similar to that of the present case, and in which the history was more completely known. For that matter, a supposititious case might be discussed, for it would be easy to introduce into it those questions which are worthy of notice. This is all the more advisable because we have the tracks of very well cleared abdominal surgery on almost all points which are under discussion with the exception of one. The patient who has been admitted to me comes under this category. She is twenty-one years of age and has a pronounced crop of acne all over her face. When a woman enters my consulting-room, and I see acne, I always ask if she has been taking bromide of potassium. This is the fashionable drug for every conceivable uterine ailment, and yet I have never heard of any one who was willing to swear that he had ever cured anything with bromide of potassium that was worth curing. Still it is the one pump handle which we have, and we work it pretty hard.

How do you recognize the fact that a patient's sufferings are real? I cannot answer that question. All that I can say is, that never in my experience have I had a woman submit to an operation, without sufficient cause to justify it. Of course, I, as all ought to do, place my statement and views, with what I propose to do and the resnlts of the operation, immediate and prospective, clearly before the patient, and, as I say I have never known a woman to submit herself to the operation without finding sufficient cause to justify its being done. You say this puts the responsibility on the patient. Well, that is what we do in every case. The patient cannot be relieved of all responsibility. A man comes to you with a diseased knee-joint. You lay before him the advantages and disadvantages of excision and of amputation, and then you ask him, "Will you have your limb amputated, or will you run the risks of excison?"

This girl is twenty-one years of age; she has to to make her own living, and this is a very important matter, indeed. If a woman comes to you whose husband has a large income, or whose friends are wealthy, the case presents altogether a different aspect. To the rich, luxury always contributes largely to the relief of pain. If a woman, whose husband has ten thousand a year, has a chronic inflammation of the ovaries, she will suffer far less than a woman who has to make her own living and has the same disease. If a woman comes to you stating that for one week out of every four she is unable to work, you are bound to perform an operation for her relief. This girl has gone through a long course of treatment. She suffers at her periods, but at other times is tolerably well. The indications for treatment are clear If a woman tells you that there is one week out of every four that she cannot work, it is clear that the arrest of menstruation will afford relief. As far as I can judge from the history of this patient, the operation which has been suggested is justifiable. You perform the operation, and what do you find? I have always found disease of the uterus or uterine appendages of some kind. These diseases are far more numerous than you imagine, and it would take a long series of lectures to discuss them thoroughly. On the left side, in this girl, there is

a feeling as though there was a mass. I think that, in all probability, it would be found that the ovaries, like the uterus, are infantile in size and probably adherent. Suppose however, that the appendages turn out to be absolutely healthy; I should still say that the operation was capable of being justified by the hisory of the case.

What are the results? In the great majority of cases there is an immediate relief from suffering and loss of blood. In some cases the relief does not come immediately; but after a time, in a few cases, relief may not come at all; but this is no argument against the operation, any more than it is against many other operations. Take the operation of cataract. This is not always a success. It is probable that in about ten per cent. of all operations for cataract, suppuration of the globe takes place, and the result may rank as mortality. In other cases escape of the vitreous or some damage to another structure will result in such chronic inflammatory change as to leave the consequential results of the operation so bad that it may be classed as a complete failure. There is no realm of surgery out of which I could not pick abundant illustrations to show that in no other branch is success any greater, if as great, as in that of which I have spoken. Immediately after the operation the patient suffers from the climacteric; but this is inevitable in the life-history of every woman who lives to the age of fifty-two. I do not think that these women, who go through these troubles in early life, suffer any more, or even as much, as those in whom it comes at the natural time. Some do not suffer much, while others suffer a great deal.

So far we have not had any trouble, except from one thing, and this is a distressing one. It occurs after all sorts of abdominal operations, after exploratory incisions, after the removal of one ovary for cystoma, after the removal of both ovaries for cystoma, and after hysterectomy. I refer to the occurrence of acute melancholia. All the cases of mental alienation that I have seen following these operations are seven in number, and all have taken the direction of this most unfavorable form of insanity—acute melancholia. I cannot say that any one of them is likely to recover. I do not know that this is a necessary result in a certain number of cases. I have performed abdominal section some 960 times, and in this number I have met with 7 cases of acute melancholia. Of course, a good many of these cases died, especially in the earlier years of my practice. We may state that acute melancholia occurs in about one per cent. of those submitted to abdominal section. I do not know that anything like this follows other surgical operations This is the only after-result of an objectionable character with which I am acquainted.

MYOMA OF THE UTERUS.

The next subject which Dr. Parvin has submitted for consideration is that of myoma of the uterus. There are two patients outside, but I do not think that it is necessary to bring them in, for you cannot see anything, and you cannot feel anything. I have examined the patients in the waiting-room. One woman is forty-eight years of age, and does not suffer much from hemorrhage or very much in any way. The tumor is hard, shrivelled, and solid, and thus it is placed in the category of cases in which nature has cured the disease. In all probability, nature will not remove the tumor, but nature has relieved the symptoms and so diminished the size of the tumor by shrinkage that nothing more will be required. The other patient is forty years of age. She has had only two hemorrhages, and it is very likely that she can be tided over the climacteric without any surgical interference. Usually, we do not operate on women for fibroma after the age of forty-six or forty-seven unless it is perfectly clear that the use of ergot combined with absolute rest is insufficient to tide her over the climacteric. When, however, the disease appears in young women, say from thirty-five to forty, or as I have seen it in a girl of nineteen, an important question comes up for careful discussion, and here again the patient must accept a good deal of responsibility in the answer. If a patient spends one week of every month in bleeding and suffering pain, becoming anæmic, restless, and irritable, unable to look after her affairs, and you cannot relieve the sufferings or arrest the hemorrhage except by operation, then this question must be considered. Is it worth while for that patient to go on suffering for a series of years when by an operation, the mortality of which is only four or five per cent., she could be relieved? On this point different men will express different opinions. If I were the patient, I should have the operation done. Holding that opinion, I advise the patient to have the operation performed.

Concerning myoma of the uterus, we have a number of traditions which are being rapidly destroyed. One tradition is that myoma is not a serious thing. We have been in the habit of finding, at our post-mortem examinations, a large number of myomata which have never given any trouble, but I need not say that the tumors which do not give rise to trouble, are not the ones which trouble us. The tumors which cause trouble are the ones which we see. If a tumor gives rise to hemorrhage and pain, the woman consults a physician, who recognizes its presence.

There is another tradition, that the occurrence of the climacteric arrests the growth of the uterine myomata. It is now perfectly clear that a certain class of uterine myoma arrests the progress of the climacteric. Frequently we find women going on for years after the usual time of the climacteric,

without any appearance of diminution in the size of the tumor, or in any amount of the hemorrhage. There is a peculiar kind of uterine myoma which causes but little pain or hemorrhage, but which goes on indefinitely increasing in size, and seems to be unaffected by the the climacteric.

In uterine myoma, provided the use of ergot and rest does not give relief, one of two procedures may be adopted. The uterine appendages may be removed and menstruation, which seems to be the immediate process by which the growth is encouraged, arrested. It is a fact established beyond discussion that in the great majority of cases operated on hemorrhage is immediately arrested, and the tumor shrivels up, and may disappear. The removal of the uterine appendages is an operation to be recommnded in a certain class of cases. In some cases in which the disease is not arrested by the removal of the uterine appendages, there is the far more dangerous operation of removal of the entire uterus or hysterectomy.—*Med. News.*

Tumors of the Bladder; Cystotomy—Dr. J. L. Little (N. Y. Surg. Society) presented a number of tumors which he had removed from the bladder of a patient in St. Luke's Hospital, who gave the following history, which was kindly furnished by Dr Ludlow of the house staff: "James McA., aged forty-nine, married, a car-driver by occupation, and a native of Ireland. His family history is good. About eight years ago he had a sudden hæmorrhage from the bladder while urinating. For two days previous he had micturition and pain at the symphysis pubis. From this time up to one year ago the hæmorrhages recurred at intervals of three or four months, and lasted about as many days. During all this time micturition was not very frequent, and he continued at work. About one year ago the quantity of urine voided steadily diminished for about one week, and then stopped altogether, and it was necessary to resort to catheterization. Since this time he has constantly used the catheter, as he has been unable at any time to pass more than a small quantity of urine, and that with great pain. The desire to urinate has become more frequent. The patient was sent to Dr. Little's clinic at the post-graduate school, by Dr. W. B. Wallace, about two months ago. "On examination, no calculus was found, and it was discovered that the introduction of a sound or a soft catheter was always followed by a fresh hæmorrhage into the bladder. He was able to hold his urine without pain for six or eight hours at a time. The symptoms indicating a growth in the bladder, he was sent to St. Luke's Hospital for an exploratory operation. A consultation was held and the operation advised. An examination of the urine showed pus, blood, mucus and triple phosphates. No casts or shreds of tumor were found.

"On October 27th Dr. Little performed median cystotomy. On introducing the finger, a number of soft tumors could be detected These were situated at the trigone of the bladder, between, and extending beyond, the orifices of ureters. A number could also be felt attached to the upper surface of the bladder. The situation of these growths being distinctly made out by the finger, Thompson's tumor forceps was introduced, and the tumors were seized and twisted or bitten off from their attachments. It was found necessary to enlarge the opening in the bladder by a slight incision downward toward the prostate in order to introduce the forceps with facility. Twenty distinct masses. most of them seeming to be separate tumors, were removed. These varied from the size of a hazel-nut to that of a hickory-nut. They all seemed to be villous in character. A large number of small pieces, evidently torn off from the larger tumors, were also removed. The surface of the bladder, after the removal of these growths, was left considerably roughened. Two orifices, large enough to allow of the introduction of the tip of the finger, could be felt in the situation of the openings of the ureters. These seemed to be the dilated orifices of the ureters. The hæmorrhage during the operation was considerable, but not enough to be alarming at any time. After the operation was completed, the bladder was thoroughly washed out with hot boro-salicylic acid solution. This seemed to greatly lessen the hæmorrhage. The wound was left open, no tube or catheter being used. During the evening following the operation the hæmorrhage was very free at times. Dr. Hance, the house surgeon, tried injecting a solution of tannic acid without effect; finally he succeeded in controlling the hæmorrhage by packing the rectum with ice, and applying ice-bags over the pubes.

"*October 28th.*—Patient's condition is good. Temperature 99° F., urine stained with blood." Since the last notes in the history furnished by Dr. Ludlow, and read the society, the patient had been steadily improving, passing all his urine from the penis without pain, free from hæmorrhage, and without recourse to a catheter. The microscopic examination, of the tumor would be reported at the next meeting.—*N. Y. Med. Journal.*

Foreign Bodies in the Eye.—Dr. Agnew, of New York, writes;—*Am. Prac.*—"When a patient comes to you complaining of a sensation as if a foreign body were in the eye, you first examine the eyeball from every point of view. You should then turn over the eyelids and examine their inner surface. And here I am reminded of a source of error to which I would call your attention. A few days ago a case came under my observation which illustrates the point. The gentleman had had occasional attacks of conjunctivitis for a year or more. He had then a sensation as if a foreign

body were in the eye. On turning out the right lower eyelid, all that was revealed to sight was a slight redness of the conjunctiva. But there was something in the way in which the sensation of a foreign body in the eye was exaggerated that made me suspect he had a single inverted eyelash. Ordinarly he felt as if some irritant was there which was tolerable, but suddenly there would be a cramp-like action of the eyelid, the irritation would grow rapidly worse, and the eye would fill with tears, followed by the discharge of a little mucus, and temporary relief. His beard was of a sandy color, his hair was light brown, and his eyelashes were almost colorless. I looked very carefully along the edges of the lids in search of inverted eyelashes, and saw, on the innermost edge of the lower lid, a slight curving of the inner angle. By allowihg a tear to gather upon this inner edge, I saw there was a difference in refraction in different portions of the tear, and it soon became evident that a delicate decolorised eyelash was there, which, instead of growing from the outer edge of the lid, sprang from the free edge of its inner border. I turned the lid over, and found that this delicate eyelash, which was between the edge of the lid and the eyeball, had been so long caught in that position that it had worn a little groove in the edge of the eyelid; the spasmodic action of the orbicularis, from time to time, so long continued, had embedded the eyelash in the substance of the lid. I removed it, and no further trouble was experienced. This patient had been treated in Europe for acute conjunctivitis several times, and it is possible that the eyelash was on those occasions the cause of all the trouble. An operation will be required to destroy the follicle which produced the misplaced eyelash. So, when a patient comes to you complaining of a sensation as though there were a foreign body in the eye, between the eyelids and the eyeball, you must first look for conjunctivitis. Whether this be present or not, you should then proceed to examine the eye very carefully to see whether a foreign body be present or not. Scan carefully the whole surface of the cornea and of the scleral conjunctiva, and then turn over the upper eyelid and carefully inspect its inner surface. You may then scrutinize the edges of the lids, as I have described, in order to see whether the source of the irritation be an inverted eyelash."

COMBINED VERSION IN PLACENTA PRÆVIA.—C. Behm (*Med. News*, Aug. 16, 1884) has used combined version in forty cases of placenta prævia, without a single death. This must be regarded as an extraordinarily good result for a condition which ordinarily gives a mortality of forty per cent. Hofmeier has already obtained similar results in the treatment of placenta prævia.

The operation is performed as follows: When dangerous hæmorrhage comes on the vagina should be tamponed until the cervix is dilated. This being done, and the woman anæsthetised, the whole hand is introduced into the vagina, and two fingers into the cervix. If the membranes present, the operator endeavors to rupture them with the finger, then draws the presenting part (unless it be the buttocks) to one side, at the same time making pressure from without so as to carry the buttocks down until he can grasp a foot. This is drawn through the cervix, so that the breech acts as a tampon on the lower segmant of the uterus, and the placenta is pressed against the sides of the uterus. In central implantation of the placenta the finger should be pushed through the centre.

After this version the operator waits for the spontaneous expulsion of the child, or at least complete spontaneous dilatation of the cervix, in order to complete delivery. The duration of labor after version is between one half an hour and eleven hours, the average being one or two hours.

The mortality for the children by this procedure is very great, but the chances for the mother are better. The mortality for the children is, however, no greater than by the old operation.

The causes of the great mortality of the mother under the use of the continuous tamponade is the infection through the blood and other matters adhering to the tampon.

THE USE AND ABUSE OF THE FORCEPS.—Professor Goodell made the following remarks in a recent clinical lecture (*Med. and Surg. Reporter*, June 14th): Tears of the perinæum will occur whether the physician uses the forceps or not, but in the majority of cases they come from the use of the forceps, or rather from the abuse of the forceps. Let me give a piece of advice to you as young men. When the proper time comes put on the forceps and boldly bring down the head, but when it begins to bulge the perinæum, take off the forceps. I do not think that any of you are competent to deliver the head over the perinæum with forceps. The temptation is to turn the head out to quickly, If you take off the forceps you will rarely have a bad tear, and if it does occur you will not get the blame for it. It is a very rare thing for me to end a labor with the forceps on. When the perinæum begins to bulge, I support the handles to see whether the pains are strong enough to end the labor. If so, I remove the forceps. There is such an abuse of this instrument that I sometimes think that Baudelocque was right when he said that the forceps had done more harm than good. It requires great skill and judgment to end a labor with the forceps. A physician from inexperience, or being demoralized by a long and tedious labor, is liable to use undue violence and deliver the head too quickly, or to make a traction in the wrong direction. I have myself torn the perinæum and seen many good physicians do the same. From this experience

I should recommend that, unless their be an excellent reason for contrary action, the forceps be taken off when the head reaches the perinæum. Occasionally one blade will catch over an ear and you cannot get it off; but in the majority of cases it can be removed, and that is the proper thing to do.

PRESERVATION OF BODIES FOR DISSECTION.—O. T. Freer writes from Munich that, in the anatomical department of the University, the material used for dissection seems to keep fresh much longer than he has found to be the case in the medical colleges. He learned from Prof. Rudinger that the injecting fluid used in the preparation of the bodies is a mixture of carbolic acid, glycerine and alcohol, and this method has been in use since 1882. Subjects injected with this mixture will keep fresh from two to six months, according to the quantity of injection used. For preserving bodies three to six months, the solution is composed of glycerine, 40 parts; carbolic acid, crystalized, 11; alcohol, 8. For preserving them two to three months, glycerine, 80 parts; carbolic acid, 17; alcohol, 13. The injection is made into the femoral artery, and the amount used is two to four litres, or quarts, though an ordinary subject will readily contain fifty per cent. more than the larger quantity.—*Chic. Med. Jour. and Ex.*, July. 1884.

CHRONIC NASAL CATARRH.—Dr. M. M. Brown, M.D. of Ithaca, N. Y. *(Med. Summary)* gives the following treatment for chronic nasal catarrh—where hard scabs are formed.

℞	Acid carbolic,	gtts. xv,
	Potass permang.,	grs. v,
	Aqua.	ʒ ij,
	Glycerine, q. s. ad.,	℥ ij M

To be applied to nostrils in the following manner with a camel's hair brush, nightly. Saturate a long camel's hair brush in a sufficient quantity of the fluid, push the brush well into the nostrils after having blown the passages clear of crusts, allow the brush to remain for five minutes in each nostril, or until the preparation can be tasted in the fauces. Repeat this until all signs of disease have disappeared. Constitutional remedies should also be used, such as iodine, iodide of potass, in syrup of ginger, etc. Dyspepsia and mal-assimilation of the ingestæ should be corrected in every case. When there is much discharge of an offensive nature, mingled oftentimes with bloody matter dropping into the fauces after meals and on getting up from bed, I apply the following powder once a day to the fauces and nasal passages with an insufflator:

℞	Potass permang.,	grs. x,
	Talc	℥ j,
	Bismuth Subnit.,	ʒ j,
	Hydray. chlor. corrosiv.,	grs. ij. M.
	Ft. in pulv.	

Ten grains of this powder blown upon the diseased surface behind the velum and into the anterior nares every evening works like a charm. Prepare the powder carefully. Still another formula, when the fetor is intense:

℞	Iodoform,		
	Calomel,		
	Bismuth subnit.,	aa	ʒ j,
	Talc,		℥ ij. M.
	Ft. in pulv.		

I prefer this powder to the first named in nearly all cases. For chronic sore throat I use the following solution:

℞	Hydrarg chlor. corrosiv.,	grs. ij,
	Alcohol,	ʒ ij,
	Aqua q. s. ad.,	℥ ij. M.

Apply with camel's hair brush to the enlarged follicles two or three times a week. If smarting is intense mitigate it with glycerine or a little vaseline.

PRURITUS VULVÆ.—Itching of the external genetalia is one of the most prevalent and tormenting conditions with which a woman can be afflicted. Hence, any remedy that will palliate this disorder is gratefully received by both patient and physician.

Dr. C. J. Smith of New York says:—The following formula has, in my hands, given relief when nothing else has been of the slightest benefit:

℞	Ext. geranii mas. fluid,	gtts. xx,
	Ext. belladonæ fluid,	gtts. iij,
	Zinc. sulph.,	gr. j.
	Vaseline,	ʒ. j M.

Sig.—For external application.

If the parts are not much inflamed I usually omit the belladonna. I have prescribed this in many cases, and with few exceptions, it has afforded immediate, and, in some instances, permanent relief. I have found it of value in pruritus ani.—*Medical Advocate.*

STRANGULATED HERNIA.—The *British Medical Journal* gives us the following points on the diagnosis of strangulated hernia. Dr. Englisch, of Vienna, on examining the urine of patients under treatment for strangulated hernia, has ascertained that it always presents albumen in proportion to the duration of the strangulation. If surgical means be not adopted, the albuminuria continues until the death of the patient. The quantity of albumen is not affected either by the date of the hernia, the size of the sac, the frequency of the anterior strangulations, nor by a febrile condition. When there is simple protrusion of the omentum, albumen is absent. Prof. Nothnagel attributes this albuminuria to diminished intravascular pressure resulting from the presence of a strangulated hernia. —*Kansas City Medical Record.*

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AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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The LANCET *has the largest circulation of any Medica Journal in Canada, comprising four-fifths of the entire Medical Profession.*

THE PHYSICIANS OF THE FUTURE.

Physicians and Surgeons in the British Isles, we are aware, are averse to specialism. Even those who pre-eminently excel in the treatment of particular classes of diseases, strive, by avoiding the habit of devoting themselves to these single classes, to set an example of a general rather than a limited practice. Despite this tendency, however, we cannot but think that specialism is the feature of the age. As the population increases, the amount of labour and competition proportionately increases. The result is that the law of the division of labour is now carried to its extreme limits. Nor is this law confined by any means to manual labour; intellectual labour comes equally under its operation. In short, specialism in every form is the salient characteristic of the nineteenth century. Grant Allen, in an article in the *Nineteenth Century* some months ago, very wittily pointed this out in an imaginary dialogue in which an Oxford graduate, despairing of fame in a life devoted to Greek, or Latin, or even Hebrew, Chaldee, or Syriac, vowed that he was "going in for the Ostiak dialect of Tungusian." The richness of the joke is only apparent when it is known that the Tungusks are an obscure little tribe of fishermen living on the almost unknown banks of the Yenisei, and that the Ostiak dialect is a corruption of their language by a yet more obscure neighbouring tribe.

In the science and practice of medicine and surgery specialism certainly is a most marked feature. Should it continue to increase at the same pace as it has done for some years past, it is no uninteresting and certainly no uninstructive task to see where it will eventually land the profession. And indeed, the consideration of this subject is almost a duty. The young practitioner, and especially the student, must look ahead and endeavour to foretell, and to adjust his methods to the profession as it will be, when he hopes to be in its front ranks.

What, in broad outline, has been the history of specialism during the lifetime of the medical man who was "capped," say fifty years ago? The first step in this direction was, probably, the separation of wards in a hospital for distinct diseases. Then followed entire hospitals devoted to a single class of diseases. These gave opportunities for special study, and from these arose the famed specialists of to-day. The effect of this upon the profession at large is, that the class of cases treated by the general practitioner—and by general practitioner we do not refer to those who, as Bacon says, "take all knowledge to be their province," the "physician, surgeon and accoucheur"—will gradually become more and more limited. A patient has ear-ache; he calls in a general practitioner, who prescribes morphine. The effects of the morphine wear off, the ear ache returns. He then goes to an aurist. The aurist diagnoses catarrh of the middle ear, punctures the membrana tympani, and cures the ear-ache. Any medical man could multiply such instances a hundred fold. And it is instances like this, daily occurring, that will soon teach the public to forsake the "family doctor" and resort to the "eye, ear, throat, lung, and nose doctor." The family doctor will soon be an institution of the past, and his place will be taken by a circle of doctors. Materfamilias will go to her gynecologist; paterfamilias probably to the whole round, according as he imagines it is his liver, or his heart, or his lungs, or his spleen that is affected.

We are by no means treating the subject lightly. But to come to a sober view of the case, and seriously to conjecture, on scientific principles, what will be the character of the physicians of the future. We think we shall express the opinion of the majority of the faculty in the following prophecy:—First, there undoubtedly will be men who by their fame as diagnosticians will be resorted to on the first appearance of any malady. Finding his forte

lies solely in diagnosis, and finding it impossible to be thoroughly *au fait* in other branches, *e. g.*, therapeutics, treatment, posology, etc., in the then enormously wide areas that these will cover (we speak, say of fifty years from now), the diagnostician will hand his patient over to the specialist for the lungs, liver, stomach, nervous system, and so on, just as now the ordinary practitioner hands him over to the oculist or aurist. These will in turn hand him over to the therapeutist with minute directions as to the effects he wishes to be produced upon the system and the tissues. Still more in the future, probably, there will be classes of diagnosticians and therapeutists. This is no visionary theory; the germs of such a system exist all around us if we will but recognize them. The same process is obtaining in kindred sciences; for example, in biology there are men who not only devote themselves entirely to one of the two great branches into which it is divided, morphological and functional biology, but go so far as to give themselves up to the study of one minute part of the many divisions into which each of these is broken up—as myological or osteological development, etc.

If then, we are not altogether incorrect in our surmises, the lesson for the student is that if specialism is the tendency of the day, and the all-in-all of the near future, to specialism he must devote himself—with this caution: that no specialism is possible except that which is built upon the broad foundation of a thorough knowledge of anatomy, physiology, chemistry, etc., etc.

THE ANNUAL MEDICAL BANQUETS.

The occurrence of the annual dinners of the graduates, under-graduates and professors of the various medical schools is looked forward to with much interest and pleasure. These occasions are made the opportunity of eliciting the expression of opinion of competent persons on matters connected with education generally, and medical education in particular. That this is recognized by the students themselves is evident from the large number of complimentary tickets issued, and also by the prominence given to those toasts which call forth speeches from eminent educationists and politicians. The banquets this year have been no exception in this respect, and we have been treated to some very valuable remarks by those best qualified, both from ability and experience to express an opinion. These banquets, according to the custom of the medical dinners for many years, were conducted on strictly temperance principles, and the toasts were drunk in cold water.

The annual banquet of the Toronto School of Medicine was held on the 12th ult., and was well attended. The chair was occupied by Dr. H. Bascom, supported on his right by the Lieut.-Governor of Ontario and Dr. McVicar, and on his left by Mayor Boswell, Prof. Clarke, and others. After justice had been done to the good things provided for the occasion, toast, song and sentiment followed each other in rapid succession, until far into the evening. The Lieut.-Governor in his speech, which was witty and well received, alluded to the obligation which the schools were under to the Hospital, and also gave a short sketch of the history of that institution. Prof. Clarke, of Trinity College, in responding for the "Universities and Colleges," said that in spite of expressions to the contrary there was the best possible feeling between the several universities in Canada. A scheme for the federation of the different universities is now very widely talked about, and he hoped that some such scheme would be effected so that a common standard might be obtained which would ensure degrees of fixed worth. He thought that while a multiplication of colleges was good, a multiplication of universities was an evil. He referred to Dr. Wilson's recent letter in defence of University College, and wished that Dr. Wilson had been more specific in his references to the persons who had made the charges which he combats. He hardly thought that Dr. Wilson placed Trinity University among the number, for Trinity was a non-sectarian university. Prof. Ramsay Wright responded for University College, and Principal Buchan, for Upper Canada College. The "Dominion and Local Legislatures" was responded to by H. E. Clarke, M.P.P. The "Learned Professions," "Graduates and Graduating Class," "General Hospital," "Freshmen," "Ladies," and the "Press," concluded the list of toasts, and a very pleasant evening's entertainment was brought to a close.

The Trinity Medical College banquet took place on the 20th ult., and was very largely attended. The chair was occupied by Mr. P. A. Dewar, sup-

ported on his right by Lieut.-Governor Robinson, Hon. Senator Allan, and Provost Body, and on his left by Hon. Edward Blake, Mayor Boswell, Dr. Widdifield, and others. After dinner was served the sound of the bugle announced the commencement of the toasts. The chairman delivered the opening speech, and in doing so referred to the large increase in the number of Trinity students, which made it the largest medical school in Canada, and also to the honor and success which her graduates had gained in other lands. He made a humorous defence of the students against the charge that they were a noisy, reckless crew, and concluded by proposing the health of "The Queen." "The Governor-General and Lieut.-Governor of Ontario," was responded to by Lieut.-Gov. Robinson. He referred to the large number of medical students about him but said that our vast country would give wide field and scope for their talents. Every profession in Canada had to contribute its portion to the welfare of the State, and he had no doubt the medical fraternity would do its full share thereto. "The Dominion and Provincial Legislatures," was the next toast. Hon. E. Blake, who was cordially received, said he was afraid that in the ranks of the political doctors there were more quacks than among the medical profession. Some people believed that their patient—Canada—was in rather a critical condition. It was said she had been bled too freely; that there were some organic defects in the system which ought even to render an operation necessary. But he was inclined to think that she would stand a good deal of killing. The legislators of this country had serious duties to discharge in welding the various parts of this country into one nation, and creating that unity of feeling essential to make Canada the country she ought to be. To its success was essential a widely diffused education, and a widely diffused public spirit. No man in Canada made a stronger candidate for Parliament than a popular country doctor. No man had more influence, and with the influence came responsibility. The medical profession was indeed a noble one. In the strict line of duty, it was a business of blessing. After referring to the great advances made in recent years in medical science, he concluded by wishing the profession all prosperity. Senator O'Donohoe also responded.

Dr. Widdifield responded on behalf of the "Provincial Legislature." He referred in feeling terms to several of his old friends on the staff of Trinity Medical College, and especially to one who was absent owing to recent family bereavement. He also said that he had had an opportunity of visiting the medical schools of the United States and Europe, and could say that the medical schools of Canada compared favorably with any he had seen. The "Mayor and Corporation" was responded to by Mayor Boswell, who told the students that if they went home singing their songs without shouting he would guarantee they would not be molested by the police. The "Universities and Sister Institutions" was responded to by Chancellor Allan, Drs. Aikins, Barrett and and others; "Trinity Medical School," by Dr. Geikie, the Dean; "Toronto General Hospital," by Dr. O'Reilly; and the "College of Physicians and Surgeons, Ontario," by Dr. Morton. The "Learned Professions," "The Ladies," and the "Press," were duly honored. A number of College songs, solos and glees enlivened the proceedings.

ONTARIO MEDICAL ACT AMENDMENTS.

The Committee appointed by the Ontario Medical Council at its last meeting to draft certain amendments to the Ontario Medical Act, met on the 4th ult., and after discussing certain proposed amendments, had an interview with the Attorney-General and other members of the Government, with reference to the same. The Attorney-General promised to give the matter his careful consideration. The proposed amendments were published in the daily press so that we need not reproduce them here. There can be no doubt about the propriety, nay the necessity, for the enactment of some of the clauses. Others, however, are more open to question. The first provides that no College or University shall be entitled to send a representative to the Council unless it has a medical staff of teachers actively engaged in teaching. This clause seems necessary inasmuch as there is a preponderance of college representatives, out of all proportion to the number of territorial members so that in justice to all parties it became necessary either to increase the number of territorial members or lessen the number of College representatives. Another clause which it is most desirable to have placed on the statute book provides,

"That all actions brought against medical practitioners for malpractice must be instituted not later than one year from the date of such so-called malpractice, and also that security for costs in suits for damages be given by plaintiff." It is suggested in regard to the latter that a private examination might be held before a judge of the Superior Court, and if he thought it doubtful that a conviction would be obtained against the defendant he might order the plaintiff to give security for costs. We are somewhat doubtful, however, whether such a provision can be successfully carried through the House, inasmuch as it may be considered class legislation, but it is well worth the effort. The proper payment of medical witnesses in courts of law or equity constitutes another important clause which we hope to see enacted.

One very important clause referring to the internal discipline of members of the College is urgently required. It is useless for the Ontario Medical Council to proceed against unlicensed practitioners and enforce the penalties of the Act, so long as impecunious registered practitioners are permitted to prostitute their high calling by accepting salaries from the ignorant pretenders who infest the country. The following clause, taken from the British Medical Act, giving the Council power to erase or suspend the name of any one who has been "guilty of any infamous or disgraceful conduct in a professional respect," might without any difficulty be passed through the House. There appears to be considerable objection to the proposed clause relating to the annual fees payable to the Council. Many object to the payment of an annual fee of $5, and also to the commutation life payment of $20, less the amount already paid in annual assessment dues, claiming that it is an interference with vested rights. The main difficulty appears to arise out of the inconvenience of collecting the small annual fee of $1 under the present working of the Act. If, therefore, the following clause were added, leaving the annual assessment as at present, the matter would be placed on a more satisfactory footing, viz.: that such fee shall be deemed to be a debt due by the member to the College, and be recoverable with costs of suit in the name of the College of Physicians and Surgeons of Ontario, in the Division Court in the City of Toronto.

EDWARD M. HOOPLE, M.D. L.R.C.P. etc.

Dr. Hoople of Atlanta, Ga., formerly of Toronto, who died on the 3rd of last month of typhoid fever complicated with hemorrhage of the bowels, was a young man of great promise. He graduated with honors in Trinity Medical College in 1883, and after obtaining the above mentioned British qualifications, settled in Atlanta, Ga. We have received a long letter from Dr. G. G. Roy, Prof. of Materia Medica in the Southern Medical College, giving a detailed history of his illness, and speaking in the highest terms of his professional abilities, kindness of heart, and amiability of character. We regret that the letter is too long for the space at our disposal. Dr. H. was rapidly gaining the confidence of the people in his newfound southern home, and had he lived would soon have secured a lucrative practice. His family and friends have our deepest sympathy in their affliction.

GEO. W. NELSON, M.D. C.M.

The subject of this notice was resident surgeon of the Panama Canal Company's Hospital. He came of a family of doctors, being the ninth in direct descent, and the second son of the late Dr. Horace Nelson of Montreal. He graduated with honors in Bishop's Medical College in 1879, taking the final prize. After graduation he practiced a short time in Mount Forest, Ont., and then in Marbleton, Que. His health having given way he removed to a warmer climate, and being offered the appointment in the Canal Company's service he accepted it. He filled the position not only most ably, but also amassed a valuable collection of clinical notes on the fevers of the country; and a series of meterological observations conducted by him, will throw some valuable light on the influence of atmospheric conditions on yellow fever. They will be published for the benefit of the profession, in the near future. He was a man of genial and kindly nature, frank and manly in his social relations, and much loved and respected. We tender Dr. Wolfred Nelson, and the other members of the family, our warmest sympathy in their sorrow and loss.

EDWARD JENNINGS, M.D.

We regret to announce the death of Dr. Edward

Jennings, of Halifax, N.S., at the age of 68 years. He graduated in 1843, and was probably one of the best known physicians in that city. Although brusque in manner, few men were more kindly disposed or did more charity work than Dr. Jennings. He was coroner for many years, and his positiou gave him opportunities of doing good which he availed himself of in endeavoring to bring about reforms in the social and sanitary condition of his fellow-citizens. His death will be deeply regretted by a large circle of acquaintances.

GEORGE WILLCOCK, M. D., L.R.C.P., ED.

The sudden and unexpected death of Dr. Willcock of this city, in the prime of active professional life, was a surprise to his many warm friends. He was a man of great promise, and had his life been spared a few years, he would have risen to eminence in his chosen profession. He was greatly beloved and respected, and leaves a wife (a relative of W. W. Ogden, M.D.) and one child to mourn his untimely loss.

MURIATE OF COCAINE.—In our last number we made a short note of this new and valuable anæsthetic. Since then it has been tried extensively in nearly all the cities of the new world, and the medical journals are filled with reports of its use, and the satisfactory nature of the results obtained. Its peculiar properties have been known to the profession for about a year, its use being to diminish sensibility in operations on the larynx. Dr. Koller first demonstrated its anæsthetic properties on the eye at the Ophthalmological Congress in Heidelberg, in September last. Since that time it has been tested by ophthalmologists in Europe and America with the most satisfactory results. Cocaine is an alkaloid obtained from the leaves of the erythroxylon coca. The drug is applied by instilling into (or brushing over) the part a four per cent. solution at short intervals until complete insensibility is produced, when the operation may at once be proceeded with. Reports of its use in practice by Drs. Rosebrugh and Reeve of this city will be found in another column.

AS OTHERS SEE US.—Prof. Struthers who visited Canada with the British Science Association, in his opening address in Aberdeen University, stated that he never heard better speaking than at the dinner of the Canadian Medical Association in Montreal, or more evidence of culture in the profession of any country. He also spoke very highly of our preliminary and professional examinations, and the excellent character of the teaching and examinations of our Universities. In his opinion however, better endowments were required for our scientific chairs. In conclusion he said that upon the whole the medical profession in Canada deserve the best sympathy and support from Great Britain in its efforts to maintain a good standard in the face of the depressing tendencies of the system of the neighbouring States of America.

A MATTER OF OPINION.—We have again been favored with one of those magnificeut works of art by John Rogers, 23 Union Square, New York. The following cut gives a faint idea of the design of the artist. It represents two physicians in consultation over a lady patient. One of them is ex-

amining the pulse and apparently explaining his view of the case. The other plainly shows his scorn and contempt for such a gross breach of professional etiquette and is buttoning up his coat and preparing to leave. The work must be seen to be fully appreciated. It would be most suitable as a Christmas or wedding present, or as an ornament in a doctor's office.

OTTAWA MEDICO-CHIURGICAL SOCIETY.—This Society held its first meeting of the season on Fri-

day, October 31st; the President, Dr. Powell, in the chair. The Secretary's report was read, showing the affairs of the society to be prosperous. It was unanimously decided to hold the regular meetings twice a month during the coming year. The following officers were then elected:—President, Dr. J. A. Grant; Vice-Presidents, Drs. Horsey and S. Wright; Secretary-Treasurer, Dr. Grant, Jr.

At the regular meeting, November 14th, the President delivered the annual address, which will appear in our next issue. At the next meeting the city health and local sanitary matters will be considered, the Board of Health being invited to be present.

British Diplomas.—Dr. E. M. Hewish (Toronto), has received his Diploma of the Royal College of Surgeons, England.

Drs. Dorland, Davy, Lawton and Stalker (Trin.) have taken the L. R. C.P., Edin., and Dr. W. F. Freeman (Trin.) has taken the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and Glasgow.

T. S. Covernton, M.D., L.R.C.P., Edin., son of Dr. C. W. Covernton of this city, has recently passed the examination for the Diploma of Sanitary Science in the University of Cambridge. This examination is the most severe of any of the kind in any part of the world.

Appointments.—Dr. J. J. Gardner has been appointed Visiting Physician to the General Hospital *vice* Dr. Burland, resigned.

Drs. C. A. Sharpe and D. A. Cameron have been appointed on the assistant staff of the Montreal General Hospital *vice* Drs. Graham and Ferguson, resigned.

Dr. J. E. Jenner has been appointed on the assistant staff of the Toronto General Hospital.

Dr. A. T. Carson has been appointed lecturer on Botany in the Women's Medical College, Toronto.

Personal.—The friends of the Rev. Dr. Johnston of Brownstown, Jamaica, the well-known missionary, will be pleased to learn that he has finished his medical course at Edinburgh, and has returned to the scene of his labors. He was greeted on his return most enthusiastically by his people and congregation. He took the degree of M.D. C.M. in Trinity Medical College, Toronto, and subsequently obtained the double qualification of L.R.C.P. & S. Edin. We wish him continued success and prosperity in his good work.

The New Specific for Rheumatism.—In the *N. Y. Med. Journal* for Nov. 8th, 1884, Dr. Seelye, of Amherst, Mass., gives an analysis of 118 cases of rheumatism treated with the new specific—the oil of gaultheria, or oil of wintergreen. His experience of its use has led him to place great reliance upon it in the treatment of all rheumatoid affections. It may be administered in capsules or combined with salicylate of sodium or in an emulsion of ten minims of the oil to half a drachm each of glycerine and water. Relief was usually obtained within from twelve to twenty-four hours.

Picrotoxin in Night-Sweats.—In the hope of obtaining a remedy that would control the exhausting night-sweats of phthisis, Dr. Cauldwell of St. Joseph's Hospital, New York, has made a series of experiments with several recognized remedies and has arrived at the conclusion that picrotoxin comes nearer the ideal than any other drug. It was prescribed in twenty cases, in seventeen of which the perspirations were either entirely checked or materially diminished. A single full dose $\frac{1}{30}$ of a grain at bed-time was generally sufficient to control the sweating.

Honor to whom Honor is due.—We are pleased to announce that Dr. Joseph Workman of this city was elected an honorary member of the Phreniatric Society of Italy in September, 1883; also an honorary member of the British Medico-Psychological Association in July, 1884. We congratulate the worthy gentleman upon the appreciation of his labours by his confrères both at home and abroad.

Impotence in the Male.—The following is highly recommended by Dr. Hammond, of New York:

℞ Strychniæ sulph.....gr. i.
Acid phos. dil. ....., ... ʒ i. M.

Sig.—Ten drops to be taken in a teaspoonful of fluid extract of coca before meals.

Dr. H. O. McLatchy, of Wolfville, N.S., has received a silver cup as a special prize for a specimen of apples at the fruit and vegetable show in the Crystal Palace, London, Eng.

SCHOOL HYGIENE.—A most excellent paper on "School Hygiene" was read at the Teachers' Association in the County of Essex, on the 23rd of October, by Dr. Coventry, of Windsor, Ont. It is published in the *Essex Record* for Nov. 7, 1884.

MEDICAL COUNCIL ELECTIONS.—We have been requested to state that Dr. Burritt, the present member for Newcastle and Trent, will not be a candidate for re-election. Having removed from the Territorial Division he is not eligible under the Act.

In Memoriam.

ISABELLA O. FULTON.

Born May 20th, 1844.
Died Oct. 28th, 1884.

In kind and loving remembrance of a devoted wife, and a kind, loving and affectionate Christian mother, these lines are dedicated. Words can but feebly express the many good qualities of head and heart by which her life was so distinguished. The highest welfare and happiness of her husband and family were her constant solicitude and care, and no sacrifice was too great to accomplish her desires in these respects. Her memory will ever live in their affections, and her prayers will be taken up and repeated by those who were taught them so faithfully as soon as they were able to lisp. Her husband has lost a true and devoted wife, and her children have sustained the greatest of all losses—the influence, care, and example of a Christian mother. Her goodness of heart and faithful motherly example, won for her the deepest love and admiration of all who knew her intimately. Many a poor family will sadly miss her kind ministrations during this inclement season. Though not customary to use these columns for obituary notices except for medical men who have distinguished themselves in some way, it seems only a fitting memorial to one who contributed so much to the success of this journal, by the assistance she gave her husband in his labor, to consecrate a small space to her memory.

Books and Pamphlets.

THE POPULAR SCIENCE MONTHLY FOR NOVEMBER, 1884. New York: D. Appleton & Company. Fifty cents a number, $5 a year.

"The Relations between the Mind and the Nervous System, by Dr. W. A. Hammond, occupies the leading place in the November "Popular Science Monthly." He defines mind as a force developed by gray nerve-tissue, and maintains that this force is generated wherever in the living organism gray nerve-tissue is found, citing many striking cases in support of this view. He denies that either the absolute or the proportionate weight of the brain indicates a definite rank in intelligence. This number contains also Herbert Spencer's replies to recent statements made by Frederick Harrison as to the "Origin of the Synthetic Philosophy." Two thoughtful addresses delivered at the recent meeting of the American Association are given in full —"Pending Problems of Astronomy," by Professor C. A. Young, and "What is Electricity?" by Professor John Trowbridge. "The Future of the Negro in the South" is treated in a witty but convincing manner by J. B. Craighead, who evidently knows the Southern negro well. Among other interesting articles may be mentioned "Chemistry of Cookery," "The Oil-Supply of the World," "Sketch of Professor James Hall." The number is a promising opening for Volume XXVI.

THE PRINCIPLES AND PRACTICE OF MEDICINE BY N. S. DAVIS, M.D., Chicago, Ill. Chicago: Jansen, McClurg & Co. Toronto: Williamson & Co.

This work is not a compilation, but an embodiment of the observations, thoughts, and experiences of the author during nearly fifty years of active medical practice. The matter is presented in the form of lectures delivered by him during his many years of teaching. The features which especially commend the work to the practitioner and student, are the fulness with which the clinical history of the various diseases is given, and the explicit and detailed description of the methods of treatment which have been found most effective. The author's adoption of the metric system of weights and measures is worthy of notice and commendation. Although this system has been advocated by leading scientific and medical societies, it has come into use only to a limited extent. To assist in

effecting this change, Dr. Davis has used the metric system throughout the work, giving however, in brackets, the equivalents in apothecaries' measure. The author is well known throughout the United States and Canada as one of the ablest and most original thinkers in the profession, who has won a deservedly high reputation as a lecturer upon practical medicine; and the profession is to be congratulated upon having in a permanent form the rich results of his busy professional life.

TEXT-BOOK OF PRACTICAL MEDICINE, FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE BY ALFRED L. LOOMIS, M.D. LL.D. with two hundred and eleven illustrations. New York: W. Wood & Co. Toronto: Hart & Co.

There is probably no clinical teacher of the present day better qualified to write a work on the practice of medicine. Many of his pupils will be glad to have a copy of his work for reference, and the general profession cannot fail to appreciate a work of such utility as the volume before us. The work is essentially an elaboration of the lectures given during the past eighteen years in the medical department of the University of New York. The author has done his work well, and has produced a book of which he may justly be proud. We regard it as second to none on the practice of medicine.

MALARIA AND MALARIAL DISEASES. By George M. Steinberg, M.D., F.R.M.S. William Wood & Co., New York.

This is a very exhausive, pleasantly written and well arranged work, in ten chapters: I. Mode of infection or intoxication. II. Conditions governing the evolution and dissemination of malaria. III. General effects of malaria. IV. Speculations and researches relating to its nature. V. Antidotes to malarial poisoning. VI. Prophylaxis. VII. Geographical distribution. Part Second. VIII. Malarial intermittent fever. IX. Continued malarial fever. X. Hæmorrhagic malarial fever. In these chapters the literature of the subject generally as well as the recorded experience of recent foreign writers is freely given, the whole forming a work of great practical value to general practitioners.

DISEASES OF WOMEN AND UTERINE THERAPEUTICS by H. MacNaughton Jones, M.D. New York: D. Appleton & Co.

MEDICAL RHYMES, BY HUGO ERICHSEN, M.D., with introduction by Prof. Willis P. King, M.D., Sedalia, Mo. St. Louis: Chambers & Co.

This work contains a collection of rhymes ancient and modern; grave and mirthful; rhymes anatomical, therapeutical and surgical, in short all sorts of rhymes to interest, amuse and edify all sorts of followers of Æsculapius, so says the author in his preface, and a casual examination of its contents would seem to bear out the statement. Some of the verses are very witty and humorous; some of a very high order of merit, and some very indifferent. On the whole the work is worthy of perusal, and will interest and amuse the busy doctor in his leisure hours.

INDEX-CATALOGUE OF LIBRARY OF SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY, Vol. v. Flaccus-Hearth: Washington Government Printing Office.

This extensive volume is but one of a series of which the reader may form some estimate by observing that it embraces only those subjects in alphabetical order between the words *Flaccus* and *Hearth*. The labor in preparing this index must be something enormous, but when completed it will be the most extensive work of the kind in the world.

LOCK-JAW OF INFANTS by J. F. Hartigan, M.D. New York: Bermingham Company.

Births, Marriages and Deaths.

On the 29th of October, Louis E. Day, M.D., to Jennie McAlpine, second daughter of John Harstone, Esq., merchant, Harwood, Ont.

On the 28th of October, Chas. W. Alden, M.D., of Hampton, N.B., to Margaret Hamilton, youngest daughter of Wm. Thompson, Esq., and neice of the late Hon. M. H. Foley.

In Toronto, on the 18th ult., George Willcock, M.D., L.R.C.P., Edin., aged 33 years.

In Halifax, on the 14th ult., Edward Jennings, M.D., in the 68th year of his age.

At Santa Barbara, California, on the 2nd ult., George W. Nelson, M.D., C.M., aged 26 years.

*** *The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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Original Communications.

ADDRESS ON MEDICINE AT THE ANNUAL MEETING OF THE MEDICO-CHIRURGICAL SOCIETY, OTTAWA.

BY J. A. GRANT, M.D., F.R.C.P., LOND.

Consulting Physician to the County of Carleton General Hospital; also to the General Hospital, Ottawa.

GENTLEMEN,—Thirty years have just passed since I had the pleasure and good fortune to become a member of the profession in this city. Our number was then small; we had neither telegraphs, telephones, nor electric lights, all of which have since been added, and in the immediate domain of the profession, vast strides have been made in every department, indicating alike the march of scientific advance in the field of labor in which we are called to duty. Let me thank you for the honor you have now conferred, in electing me President, and my son, Secretary-Treasurer of the Medico-Chirurgical Society for the ensuing year. I have on various occasions experienced your thoughtful consideration, and to be again honored, after so many years spent with you, is an evidence of your continued confidence, at a time when the termination of my professional career cannot be very far off, under ordinary circumstances. The life so far has been an exceedingly happy one, and my earnest desire has been to promote a mutual regard and self respect amongst our brethren, and thus unite our efforts in the discharge of the varied responsibilities entrusted to our care. The success of the medical profession depends greatly on close and continued observation, in order to eliminate the practical issues of bed-side experience, which after all is the light and lamp which cheers us on in our work. The efforts of a single individual can accomplish but little, compared with the combined exertions of various laborers in the same line of research. Each medical society should be a centre of intellectual co-operation, comparing, strengthening and fortifying, each new idea each ray of light, which may be thrown on any obscure point, until it intensifies and grows, so as to be worthy of the recognition of science. No man is perfect, and each day proves the vast importance of ascertaining carefully our facts, their mutual relations, and the deductions to be drawn therefrom. During this coming year let me invite your hearty co-operation and assistance. Our country is comparatively new, and our scientific societies and institutions, are gradually budding into practical usefulness. Canada and the Canadian medical profession are now better known in transatlantic centres of learning than at any previous period in our history, and all we desire is an honorable record. Each medical society is a parent cell of the intellectual medical structure, as a whole, of our Dominion, the reflex influence of which, for good, will greatly depend on united intellectual co-operation. Thus we will attain the esteem and good will of those at home and abroad and strengthen the ties which unite us together as a working body, working to make "our lives sublime," by the relief of suffering humanity. The march of progress in medical science we have evidence of in every department of the profession, and on this present occasion I shall invite your attention to a few lines of thought, now being thoroughly traversed, particularly in medicine, physiology, pathology, and therapeutics. The relationship of disease to minute forms of life is attracting the most careful enquiry in the field of microscopic research. Until recently, large bodies, rather than small, have engaged the chief share of attention. To-day however, we note that the small things of creation, such as fungi, blights, mildews, moulds and bacteria, so intimately associated with life and death, have aroused more than an ordinary degree of interest. By the aid of the microscope we can demonstrate those minute forms, rod-shaped, spiral, globular, filamentous, and termed bacteria, classed as vegetable parasites and capable of promoting general systemic disturbance. Earth, air and water contain these minute forms, and their mission is so directed as to manipulate the elements of disintegration and decay, and institute a purifying process. Bacteria may prove harmless or otherwise, in accordance with their peculiarity of action. In the performance of the various functions of life, thousands of these bodies enter the system, largely

through the lungs, and gradually make their way into the fluids of the lymphatics and blood-vessels. Should they find a basis of operation congenial, they will grow and multiply rapidly, and develop bacterial disease. The albuminoids and carbohydrates afford grand centres for their operation. They are active factors in putrid decomposition; transform sugar into lactic acid; lactic acid into butyric acid; alcohol into acetic acid, and sugar into a slimy gum. When these products of their activity find entrance into the human system, specific bacterial disease is produced. Then it becomes a question which shall prevail, the tissue cells of the system, which by their inherent power may overcome bacterial influence, or the bacteria overpower the system and induce death. They have a congenial soil when in active operation. The bacillus of splenic fever and consumption, and the bacillus anthracis, have their own characteristics, and may by cultivation part with their dangerous power, as far as promotion of disease is concerned.

Pasteur has demonstrated beyond doubt, that by introducing a minute quantity of diseased structure charged with its specific bacteria, into the tissue of healthy animals, that the identical disease is reproduced. What is still more interesting is the fact, that virulent and poisonous bacilli, can by cultivation, be so changed, as to part with their poisonous power. Here comes in the vaccinating principle of the bacillus; its prophylactic action against invasion of the original disease. We constantly observe in practice, how an attack of scarlet fever, measles, etc., almost precludes the possibility of a second such occurrence. The precise power is difficult to define, and parasitic action may be the chief factor in the remarkable protection. We know well what vaccination has accomplished, and the same principle may yet be so arranged as to place under control many zymotic diseases which still scourge the human family. The question of the precise relationship of organisms to the processes of putrefaction and fermentation, is beset by diversified views; followers of Pasteur's germ theory, holding that bacteria are invariably the initiators of these chemical changes, while others contend that putrefaction and fermentation may take place, independent of these low forms of life. The question of cause and effect, as associated with bacteria, is an interesting problem, and now engaging the attention of master minds, particularly with reference to the cholera microbe, and the bacillus of tubercle, and let us hope that the result will be both practical and useful, as far as the arrest of disease is concerned. While on the subject of the cholera microbe let me remark, that judging from present indications, cholera is most assuredly gradually moving onward in the course previously taken in 1832 and 1854. In Paris the daily death-rate is quite alarming. The present is the time for activity in carrying out sanitary precautions, so as to be prepared for the advent of spring. Through steam, commercial communication has rapidly increased, and centres of trade thus placed in close relationship, hence the necessity for prompt action. Sanitary rules and regulations are of little service, unless carried into operation. Prevention is a powerful factor, and let our efforts be so directed as to guard the best interest of our people. In this brief introductory I find the subjects so closely interwoven, that with difficulty can the line of thought be isolated. Physiology and pathology have so much in common that they never can be separated, because as sciences they have the same organs and the same functions, under normal or abnormal conditions. It is important that the normal or abnormal condition of an organ should be studied, on the principles of a mutual intercourse. Functional activity and organic change are co-operating powers closely interwoven, which must be noted carefully, in the broadest sense, as progressive evolution in tissue occupies the place of the once healthy organ. Thus comes in the important application of physiological discovery, as an additional prospect for the relief of diseased structure. Lymphatics and leucocytes are points at present possessing more than an ordinary degree of interest, as to the precise part they play in the structure and functions of the system. Blood and lymph are the chief juices of the body, and on that account the purity or impurity, the normality or abnormality of either, directs, controls and determines the powers of the system in structural development, as well as decay. According to Zeigler, the lymph is merely the liquid transuded from the blood vessels, together with certain products of tissue metabolism, and certain matters taken up by the lacteals from the outside. The sources of lymph being so diversified, it is not surprising that occasional morbid changes in its composition

should take place. Until recently the mediastinal and mesenteric glands were the chief source of attention in this important department of absorbing power. In this field of labor Dr. Philipson and Professor Redfern have certainly rendered most valuable service. The lacteals and lymphatics are constantly occupied in supplying the blood with fresh material, from two great sources of life, air and food, and thus become supplementary to the general vascular system. It is a settled point that in the extremities, the deep and superficial lymphatics communicate only in the glands, and that the pleura, peritoneum and pericardium, are not closed cavities, but immense lymph sacs, communicating with lymphatic capillaries, by means of stomata. Thus we observe the existence of an additional lever as to the absorption of abnormal products, and a system of escape, into the general lymphatic channels. Hoggan (*Journal of Anatomy and Physiology*) has defined a newly observed disease of the lymphatics, viz., multiple lymphatic nævi of the skin, thought to be quite as common as venous nævi, which it frequently complicates, and is also the initial or predisposing stage of other diseases, such as lymphatic varix of the larger vessels, and also of elephantiasis. Dilatation of lymphatics is most common in warm and moist climates, and to Manson we owe the interesting discovery, that a prolific cause of dilatation in these vessels, is owing to plugging by the aborted ova of the "Filaria sanguinis hominis." The causes and processes of disease, now occupy more attention than anatomical results; and the experimental production of disease is slowly working its way, and will doubtless lead to very important data. How strangely blood, the great vital fluid is disposed, and its abounding leucocytes. What their function, or what part they play in the economy, is yet unsolved. From the fact of being in the blood so abundantly, we would suppose an intimate relationship, with life-giving processes of action. On the other hand however, we note numerous masses of leucocyte-shaped cells, in the vessels surrounding, rapidly developing sarcomatous tumors. Are there leucocytes of life, and leucocytes of death? Long since the blood was considered as the source of cancer, and certainly the close affinity of leucocytic action becomes an exceedingly interesting physiological problem. Another constituent of blood intimately associated with structural development, and at times ejected as abnormal material, is albumen. Clinically its importance has undergone considerable modification, as far as constantly being a factor of organic disease is concerned. In truth it is known that we may have kidney disease, minus albumen, and *vice versa*. Johnson, of King's College, London, affirms that "the smallest trace of albumen in the urine is always pathological." It is "the frequently recurring and persistent albuminuria which is found to be sooner or later associated with serious structural degeneration of the kidney." By far the most numerous cases of albuminuria, are those occurring in persons supposed to be healthy, but who at some previous period, have had an attack of acute renal trouble. Quasi health with latent disease, frequently follows such attacks, and cannot be too cautiously guarded. It is interesting to have in view the fact that while urine voided before breakfast, and after a night's rest, is free from albumen, yet, after food and exercise, it may become abundant. Renal or non-renal albuminuria, is the question. It is known that frequently, both before and after menstruation, for a few days at least, the urine may contain a small quantity of albumen. Various trivial causes are cited as producing albumen in the urine, and amongst others, indiscretions of youth. The absence of constitutional evidences of renal disease, with urine normal in every other particular, excepting albumen, would point to a local origin, non-renal in character. Albumen under any circumstance cannot be too critically examined. In Canada my observation leads me to the belief, that the most prolific source of kidney-trouble, is alcohol; not alcohol in large quantities, but the quiet, and regular use, in the daily round of life. Many escape this disease, thanks to the power of their kidneys, but on the other hand, not a few come to grief. Night micturition is an early indication, and alcohol has actually been found in the urine, having escaped thus, from the over charged system. Albumen is, then, only sometimes present. Too much stress cannot be placed on the power which alcohol exercises on the system, even in moderate form, towards the development of albuminuria. The study of diseased manifestations, naturally leads to the means at our disposal, the therapeutic lever, and how to be applied. The only true method by which practical results can be achieved, is by experiments on the lower animals;

statistical observation of the results of treatment, and lastly individual observation. Could our local society not be constituted a collective investigation committee? At present each member works in a practice circle of his own. Could the various circles be united, as to practical results, much valuable information would be brought together. What can possibly be more diverse than the treatment of disease? In many diseases, the very multiplicity of remedies recommended, by the most advanced authors, for the relief of the same, tend to throw doubt on therapeutic action. Cholera, diphtheria and typhoid fever. How varied the recommendations for this tripod of disease! The uncertainty of medicine is well known, and still how frequently we note its practical utility. The non-reliability of the materia medica is daily decreasing, and how? by the careful and patient study of philosophical and physiological facts. Thus the reactions in human chemistry are worked out on plain and simple principles, providing nature's laboratory is not overburdened by the endless variety of pseudo-medical nostrums, placed before the public in popular form. It is somewhat remarkable how few of the many therapeutic agents upon which we pin the greatest reliance, have been the result of direct experiment, or scientific enquiry. We recognise the power of quinine in intermittent fevers, and debilitated states of the system generally, and yet how defective is our knowledge as to the precise action of this material on the system. Again, we all note the power and influence of bromide and iodide of potassium, and yet their employment has not been the result of scientific induction, as the outcome of either physiological or pathological enquiry. In this line of thought much doubtless has been accomplished, but there is still much to learn. In Canada fortunately there is no legislative enactment against "vivi-section," one of the greatest possible blessings of humanity, as a means of carrying out scientific research. In the development of Canadian history and interests, we hope to see more time and means devoted to original investigation. Discoveries, through scientific enquiry, in the direction of the human system, would be exceedingly gratifying records, in the march of progress in our new country. We have an intellectual activity of no low order, and with our na ive growth, schooled at home and abroad, in the most progressive centres of Great Britain and Europe, we naturally look for, and anticipate competitive scientific enquiry, into the complex operations of a system which has thus far taxed the most acute observation in solving the problems of life. "Not what I have, but what I can do, is my kingdoms," says Thomas Carlyle. Fortune may not be our lot; but an honest living we shall have, and with the trust placed in our hands, let us so discharge our duties as to gain the esteem and respect of our fellow-men.

A RECORD OF CASES TREATED IN THE ROYAL INFIRMARY, FROM NOV. 1883 TO MAY, 1884.*

BY ANGUS MACDONALD, M.D., F.R.C.S.E.
Physician to the Infirmary.

FIBROID TUMORS OF THE UTERUS.

A. N. æt. 36, unmarried, was admitted Nov. 5, 1883, complaining of a swelling in her abdomen. Patient has always enjoyed good health till three years ago, when she felt a severe pain in her back which lasted only three days. Twelve months before admission the same kind of pain returned and since then it has been constant. The pain induced her to go to the doctor who told her there was something wrong with her inside, and advised her to go to the hospital.

Condition on admission—Abdomen distended to about the size of a seven or eight months' pregnancy, but somewhat irregularly, the long end of the oval being oblique upwards from left to right, from the middle of Poupart's ligament on the left side to the top of the last rib on the right side. Tumour is perfectly moveable. Percussion is uniformly dull anteriorly, resonant on both sides, especially on the left. On the right the tumour feels solid, on the left obscure fluctuation is present. In front a soft flat cyst containing fluid can be distinctly felt and it is freely moveable over surface of solid mass behind. On auscultation an impulse is communicated to the ear from all points of the surface of the tumour. On the lower aspect anteriorly a distinct bruit is audible synchronous with heart's first sound. *Per vaginam*—Hymen persistent, pelvis empty, and the vaginal portion of the cervix is represented by a button-like nodule of firm tissue. From this nodule the thinned elongated cervix can be felt extending up-

* Read before the Obstetrical Society, Edinburgh, June, 1884.

wards to the tumour, a distance measured by the sound of between two and three inches. Nov. 23, 1883, Dr. Macdonald opened the abdomen; there were no adhesions whatever. Before the tumour could be removed the incision had to be extended gradually from the symphysis pubis to 1½-2 inches above the umbilicus. Both ovaries were high up and placed the left anteriorly and the right posteriorly on the tumour. There was a marked twist from left to right forwards; the amount of rotation was quite a quarter of a circle. The neck was elongated and formed a fairly good pedicle. This was embraced by Tait's clamp and secured. The tumour was now cut off about an inch above the clamp. There was very free hemorrhage from the tumour during the operation. The end of the stump did not bleed at all. A further portion of the stump was removed by scissors. The abdominal wound was now secured by thirteen deep and numerous superficial sutures. A quantity of salicylic wool was placed over the wound, a bandage applied and the patient put to bed, and attended to in the usual manner. The whole operation took sixty minutes, and the tumour weighed ten pounds. The patient made an uninterrupted recovery; the highest temperature registered during the convalescence was 99.4 which occurred at 11 a.m. on Nov. 24; pulse averaged 65. Over the stump a little powdered iodoform was sprinkled. No opium was administered. The bowels were moved with castor oil for the first time on 1st December. The deep stitches were removed on the 9th day when complete union by first intention was found throughout. The superficial stitches were taken out on the eleventh day. The clamp separated on Dec. 16th, 1883. January 24, 1884, wound quite healed. The end of the vagina could not be reached; patient discharged.

Remarks—The operation in this case was necessitated by the pain occasioned by the rapid growth of the tumour. There was no trouble from bleeding. The medical attendant who sent the patient reported that the tumour appeared to him to double its size in the course of two months. The bulk of the tumour was made up of degeneration of the anterior wall of the uterus, the body of the organ being round its posterior surface. The marked twist in the tumour is of importance in its bearing upon the treatment of removal of the ovaries for the purpose of arresting the growth of fibroid tumours. Whilst the left ovary could have been easily removed it would have been completely impossible to reach the right. Before proceeding to operate we had made out clearly that the tumour was clear of the pelvis and had an elongated cervix, two points of the greatest importance in facilitating the operation. The loss of time which occurred in sewing up the abdominal wound arose from the efforts made to secure as completely as possible the lower angle of the wound below the pedicle. In attempting to do this the needle broke and led to considerable delay.

CASE II.—M. B. æt. 54, admitted Feb. 21, 1884, complaining of a swelling in her abdomen and of pain in the swelling. Patient first noticed a lump in her abdomen eight years ago, since that time the lump has gradually increased in size, and during the three weeks previous to her admission it has rapidly grown much larger and feels harder and more pain is present. Patient also states that for two or three weeks before admission she has passed less water than previously, and there has been a disagreeable pain in her back.

Condition on admission—Abdomen is occupied by a large tumour distended to the size of full-termed pregnancy. Tumour is hard, moveable, rounded, smooth and oval in shape. Friction is heard anteriorly, soft bruit is audible, synchronous with first sound immediately above pubis in mesial line. Measurement round most prominent part (3½ inches below umbilicus)=47½ inches. From right ant. sup. spine of ilium to umbilicus 8¾ inches, from left ditto 9 inches. From umbilicus to pubis 9 inches, from umbilicus to ensiform cartilage 9 inches. All over surface of tumour percussion is dull, flanks clear, also clear between ensiform cartilage and upper border of tumour. Vagina rather narrow and elongated, cervix can be felt with extreme difficulty at its upper part, at a level with the upper edge of the symphysis; no part of the tumour can be felt per vaginam, but only one finger can be passed. Sound enters upwards and towards right side, three inches Urine passed in 24 hours was 24 oz., containing albumen, blood, pus, renal epithelium and blood casts. Patient was put on milk diet, the quantity of urine increased to 50 oz. during the 24 hours, and the week before she was operated on only a trace of blood and albumen could be detected. On the 4th of April Dr. Macdonald performed laparotomy.

The peritoneum was speedily reached; on passing the hand round the tumour it was found to be free from adhesions. The uterine tumour had so developed as to bring the left ovary forwards and upwards as high as the umbilicus, thereby producing great tension on the left broad ligament. The incision was gradually increased by one-quarter inch at a time, upwards, until the tumour could be pushed through. It was then found that the tumour had a very short pedicle; round this was passed a Tait's clamp, which was securely tightened. The tumour was now cut off, about an inch above the clamp; the hemorrhage was found to be completely arrested by the clamp. The edges of the incision were now brought together by deep and superficial stitches. The superfluous tissue of the pedicle was cut off by scissors and the stump dressed by being freely dusted over by a mixture of equal parts of bismuth and iodoform. The rest of the wound was covered by a layer of protective lint. The woman was then put to bed and had a brandy enema administered. The patient made an excellent recovery. The highest temperature reached was 99° F. She passed wind on the third day, and the bowels were moved on the eight day after castor oil had been given. The deep stitches were removed on the seventh day, the clamp on the 30th of April. The tumour weighed eight pounds.

Remarks.—In this case also the operation was required on account of the bulk and rapid growth of the tumour. It was found to be developed in the posterior uterine wall, the body of the uterus being stretched over its anterior surface. In this case also, removal of the right ovary which lay behind the tumour low down would have been impossible. There were several considerable cavities developed in this tumour, indicating its tendency to fibro-cystic changes. It is also to be noted that the pressure of the tumour appeared to have caused the renal disturbance noted on admission. At any rate when the patient came in there was scanty urine containing blood, casts and albumen. Rest and appropriate treatment speedily rendered the urine both plentiful and healthy. The pedicle in this case was exceedingly short, and as the patient's abdominal walls were very thickly covered with adipose tissue, the clamp sunk deeply into it, and on the left and right side caused a certain amount of ulceration, but on the removal of the clamp these symptoms rapidly improved. The difficulties connected with the external method makes us sigh for a valuable internal method in this operation; but the risks of bleeding and of infection are so great that I have not seen it advisable to attempt the internal method ably practised by Schroeder.

CASE III.—M. A. B. æt. 51, admitted January 9, 1884, complaining of enlargement of the abdomen. Patient has menstruated during the last seven years, but her abdomen has been gradually increasing in size. Appears in good health apart from the inconvenience of the tumour.

Condition on admission.—The abdomen is occupied by a more or less rounded, moveable, resistant, hard tumor. Abdomen widest girth measures 39½ inches. Percussion absolutely dull up to 1½ inches below umbilicus, in both flanks note clear. Auscultation gives negative results.

Examination per Vaginam. — The posterior part of the pelvis at its upper end, and a great part of the inlet is occupied by a large tumour, soft anteriorly, hard posteriorly. Arching in a semilunar manner in front of the anterior part of the tumour is a thin, valve-like tissue, which seems to be the thinned anterior lip of the cervix. Using this as a guide, the sound passes up and towards the right 3½ inches. This case admitted of no surgical treatment, more especially as there was no hemorrhage to complain of, and she was dismissed on 24th Jan., 1884, in *statu quo*.

CASE IV.—J. D., æt 43, admitted Feb. 15, 1884, complaining of a tumour in her abdomen. Patient first noticed the tumour four years ago; it has grown slowly and has not been uneasy lately. Menstruation was profuse, but is not so much now as it was nine months ago.

Condition on admission.—The lower part of the abdomen is projected by a tumour of uneven outline, which extends as high as the umbilicus. It is firm, not tender, and freely moveable. On the lower parts of the tumour a bruit synchronous with the heart sound is audible. The girth round the most projecting part of the tumonr is 34 inches. Vaginal examination reveals a rounded tumour occupying the posterior part of the inlet continuous with the tumour in the abdomen and moving with it. In front of the os there is also projecting into the anterior part of the pelvis a rounded mass similarly related to the tumour. Sound en-

ters upwards and forwards barely 3 inches without pain. The patient is rather anæmic. She was ordered ergotine suppositories and a chalybeate tonic, and after a rest in the hospital was dismissed on March 23, 1884, as an unsuitable case for operative interference.

CASE V.—M., æt. 78, was admitted on April 9, 1884, complaining of a continual sanguineous discharge and pain in her back. Her illness dates from a miscarriage she had 7 years ago. Patient has had six children and two miscarriages.

Condition on admission.—Patient is very *anæmic* looking; a systobic murmur is present in all the cardiac areas. Abdomen occupied inferiorly by a rounded, moveable, almost fluctuating tumour, which extends 5 inches above the upper edge of symphysis pubis. The tumour is more developed toward the left than toward the right, although on the whole it is centrally placed. A bruit is heard immediately above the symphysis. Per vaginam the cervix is reached with some difficulty. It is considerably undone, the lower os being traversable to the examining finger which passes in 1½ inches, cervix passes right into tumour which is moveable. No part of the tumour is contained in the pelvis. April 23, patient left hospital owing to domestic affliction.

Observations.—The foregoing cases differed considerably in symptoms and conditions. In case 3 there was no hemorrhage, but the patient applied for relief on account of the bulk of the tumour. There was, however, no evidence to show that the mass was growing fast, and the absence of bruit indicated no great vascularity in the tumour. The difficulty and the risks of removal, when the cervix was undone, and the tumour found to grow so deeply between the layers of the broad ligament, appeared to me so great that I declined to interfere by operation, and accordingly the patient left. I have not heard from her since. Indeed such cases present insuperable difficulties to removal, partly because there is nothing from which to make a pedicle, and partly on account of the enormous adhesions which are found round the mass when the broad ligament is opened up and the downward and outward growth of the tumour occurs. The same remarks apply to cases 4 and 5, only that in regard to them the bleeding was an urgent symptom. But in case four the hemorrhage though still present, appeared for several months past to be steadily diminishing; accordingly, I contented myself with recommending ergotine and iron, in the hope that the patient's strength might be kept up until the menopause was fully established, when there is every reason to expect the tumour would shrink and give little further trouble. But case five presented so much distressing bleeding that operation was seriously contemplated. The case did not present a good one for hysterectomy as though there was no pelvic adhesion and no considerable opening out of the broad ligament, the length of the cervix was so encroached upon as to render it all but impossible to get such a pedicle as a clamp could secure. Accordingly I had made up my mind to try the effect of the removal of the ovaries in the hope of inducing a premature arrest of menstruation, and thus removing the most pressing symptom, viz: dangerous flooding. The sudden illness of a daughter of the patient led her to leave the hospital unexpectedly. She was to return if the bleeding continued to be serious, meanwhile she was to employ ergotine and quinine pills. She has not as yet applied for readmission.

ON RAILWAY SPINE.*

BY. J. CAMPBELL, M.D. L.R.C.P., ED., SEAFORTH, ONT.

The ever-interesting and ever-important subject of what now generally goes by the name of "Railway Spine" has, during the last year, been attracting renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years a surgeon to one of the greatest railway corporations in England, and, therefore, has had a very extended experience of all possible railway injuries, and particularly of cases of so-called "railway spine." He contends that cases of what are commonly called concussion of the spine do not exist, except in the imagination of the surgeon making the diagnosis. By "concussion," he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt. It is well known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms

*Read before the Canada Medical Association, Aug., 1884

spinal symptoms are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He at least conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or the ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the the other hand, maintains that these so-called cases of "spinal concussion" always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort. Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post-mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post-mortem investigation. The great trouble in coming to an opinion as to the nature and causes of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change but whether we have to do with an actual or feigned train of symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble; but when he has to do with an intelligent and unscrupulous man, who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis. In the words of a recent writer, "the needed clinical work, it seems to us, in the study of "railway spine," is the determination of clearly defined types of the disease and the investigation of the varieties from this type and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of *Brain*, there is a very instructive case reported by Dr. Edmonds of a soldier who was struck in the back with a bullet. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bedsore over the sacrum before death, which occurred five months after the injury. At the autopsy, there was no fracture or indication of fracture or dislocation of the vertebræ to be found. The corda vertebralis was intact. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound; this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts and above into sclerosis of the posterior median columns. There was no indication of hemorrhage, either external to or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause The case is then one of very great importance, as it proves most conclusively that we can have, from a severe shock, sufficient changes brought about in the spinal cord to bring about death, and that these changes are, in the first place, nothing more nor less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have a tabes dorsalis arise from peripheral causes; that in fact, an ulcer in the foot may be *fons et origo mali* of this formidable disease. The origin of the disease in such a case is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

EXTENSIVE RUPTURE OF THE URETHRA WITH SATISFACTORY RESULTS.

BY CLARKSON FREEMAN, M.D., MEILTON, ONT.

On the 21st of February, 1884, W. R., æt. 29, farmer, fell from the top of an ice house, a distance of over ten feet, astride the edge of an inch board sleigh box. There was no abrasion of the skin, but

blood came freely from the urethral canal at the time of the accident, and oozed continuously for ten days. He was unable to urinate, and after several ineffectual attempts to introduce a No. 10 catheter I succeeded with a No. 5 gum elastic one, which remained nine days, and was replaced by numbers 6, 7, 8, 9, 10, 11 and 12 consecutively, at intervals of, on an average, seven days, according to the degree of irritation, or the presence or absence of vesical tenesmus. The rupture was nearly three inches in extent on the under surface of the urethra, between the scrotum and the prostate gland. The patient was kept constantly in the recumbent position, with his legs flexed, in consequence of his testicles being painfully swollen and extensive tumefaction of the perineum with ecchymosis from the anus to the prepuce of the penis, which remained for weeks. He had high fever with chills for some days, resulting from the formation of an extensive perineal abscess, which I opened on the 8th of March, to the great relief of the patient. The matter was copious and characterized by a most abominable stench. Under the use of disinfectants the abscess soon improved, but continued to discharge until the 15th of June. On the 14th of March by neglecting to remove the plug from the catheter in defecating, the urine was forced around the catheter and made its exit freely from the perineal opening. This frequently occurred afterwards by the slightest effort of straining. The abscess was syringed freely with milk and a small quantity of liquor morph., after each occurrence, as well as the bladder, whenever there were symptoms of mucus or approaching vesical tenesmus, which always mitigated the patient's intense suffering. The shortest time the catheter remained in the bladder was four days, and the longest 13 days. The fistulous opening thus formed from the abscess remained about three months, through which urine frequently escaped freely towards the last without producing any pain or uneasiness. The catheter was retained in the bladder continuously for 68 days after the receipt of the injury, until prostatic pain occurred and blood began to ooze from the bladder. On consultation with my brother, Dr. Wm. Freeman, the catheter was removed. The volume of urine was greatly increased and came away without the slightest effort for five days, when it began to diminish gradually until the ninth day, when he was unable to micturate. Number 8 catheter was passed with slight difficulty beyond the seat of stricture daily, and 9, 10, 11 and 12 were again used at intervals, but not allowed to enter the bladder. No. 11 was mostly used before micturition. This precaution was persevered with over a month, until a perfect cure has resulted in one of the gravest accidents which may occur to any person.

He had frequent attacks of orchitis, which were allayed by hot fomentations, and the subsequent use of the suspensory bandage. I would suggest the use of vulcanized rubber catheters in the treatment of analogous cases, as they do not become easily corroded by constant use.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—As a tribute to his worth, and as a matter of sad intelligence to many of your readers, I have thought a brief history of the sojourn, sickness and death of Dr. Ed. M. Hoople, of Toronto, Ontario, Canada, in this city, might prove acceptable to the columns of your very able and excellent journal. About six months ago, after an extended prospecting tour through most of our western States and Territories, Dr. H. reached this young metropolis of the south, "a stranger in a strange land." A partnership was suggested to him by a friend, and he called upon me with that object in view. I told him that though frequently solicited, I had never thought it expedient to take in a partner, but would very cheerfully extend to him the privileges of my office, and assist him in establishing himself with our people by every means in my power. From that hour until the advent of his last illness, he was my daily companion, friend and valuable assistant.

Dr. Hoople was a young man of thorough medical education; an honored graduate of the Royal College of Physicians and Surgeons, Edinburgh, and one who, had he lived, was destined to add lustre to the bright galaxy of names which already adorn the roll of graduates of that renowned institution. He was a man of modest, retired and cultured deportment, self-possessed in the confidence of his ability to "measure lances" with the best trained medical men of his age, from the thorough medical training to which he had been subjected,—yet, withal, having too much self-

respect to obtrude his opinions or judgment uninvited. His mind was analytic and quickly synthetic; his memory unusually retentive; his heart was unselfish and sympathetic, and his hands ever ready to assist those in need of help. He placed but little value upon money, save as a means of contributing to the comfort and happiness of others. With such a character as this, it is needless to say that in his new-found southern home, which he seemed to love with a pride and admiration as if begotten of many years of residence here, he soon won a host of friends, whose daily evidences of esteem in life, whose untiring and tender care and watchfulness during his illness and when death had cast its sable mantle over his noble frame, whose moistened eyes, soft and noiseless steps and low whisperings of love and sadness round his bier, more sweetly and beautifully attested their devotion, than empty words can express. He was fast gaining the confidence of our best people as to his professional abilities and skill, and had he lived, would soon have reached a self-sustaining if not a lucrative practice. He was fond of surgery and while here performed several skilful and delicate operations. He was taken down on the 25th of October with typhoid fever, complicated with hæmorrhage of the bowels, and died on the 3rd of November. I am greatly gratified to say to his aged mother especially—whom he loved and reverenced with the purest filial devotion—and his friends generally, that I believe he found peace, consolation and salvation by trusting in the atoning blood of Jesus Christ.

He had every attention that tender and skilful nursing could give. His prayers for the kind friends he had made, and especially for those who had waited and watched so lovingly and constantly over his sick bed, brought tears to the eyes of some unaccustomed to weep on such occasions. We feel comforted in the reflection that his was one of those cases in the experience of every physician, when every remedy has failed, which teaches us the impotency of man and the omnipotence of God.

Yours, etc.,

G. G. Roy, M.D.,

Prof. Materia Medica, Southern Med. Col.

ATLANTA, Ga., Nov. 25th, 1884.

Selected Articles.

REMOTE PUERPERAL HÆMORRHAGE.

Prof. T. Gaillard Thomas, M.D., of New York, gives the following in the *N. Y. Med. Jour.*, Sept. 6th:—Since I last attended a meeting of the society I have met two cases which have suggested to my mind the considerations which form the basis of what I am about to say. I refer to a form of hæmorrhage which comes on three weeks or a month after labor, after the physician has ceased making his visits. Some years ago the late Dr. M'Clintock, of Dublin, wrote a paper on this subject, and called it "remote or delayed puerperal hæmorrhage," and Dr. Mundé has recently written an article bearing upon the same point, published in the "American Journal of Obstetrics." I have seen a good many of these cases, and the history of one which I will relate illustrates the experience that I have had with most of them.

In such a case the uterus may have contracted after labor, and everything have gone on properly until the ninth day, when the physician has ceased to make his daily visits, but from that time the woman begins to lose blood steadily. If she makes a little unusual effort, or if anything occurs in the family to cause considerable mental excitement, an exceedingly dangerous hæmorrhage may take place, which will require to be checked with the tampon. If sudden and profuse hæmorrhage does not occur, demanding the services of a physician immediately, a steady loss of blood in moderate amount may continue for a week or ten days, until the woman becomes very much exhausted.

The particular case of which I have had the history in mind in the foregoing remarks, was that of a lady to whom I was called in consultation by a German physician of considerable experience. Ten months before, the patient had called at my office, and had given a somewhat peculiar history. She had been married for several years, her husband was a vigorous, healthy man in every respect, and she a remarkably handsome and well-formed woman; and yet no intercourse had ever occurred. On examination, it was found she was suffering from a very aggravated form of vaginismus. Her husband had exhausted all his efforts, and her mental state had become such that she could not entertain the thought of sexual intercourse. An operation was performed, at the end of a month the patient left the hospital, and just nine months later she was delivered of a child. About the end of the seventh month of gestation the veins leading from each labium majus became greatly enlarged, and the parts presented the appearance of a mass of earth-worms of the size of one's fist. I had seen the condition in so marked a degree but once or twice before.

On the ninth day after delivery hæmorrhage occurred, and she sent for her physician, who used all the ordinary means, including ergot, tannic acid, dilute sulphuric acid, etc., for stopping it, but without avail. The tampon, however, was not resorted to. About three weeks after her delivery the patient was seized with very profuse and violent hæmorrhage, which reduced her very much. It came on after she had got out of bed. When her physician reached her the hæmorrhage had ceased. Each time it had begun with the passage of a large blood-clot. On this occasion I was consulted, and I visited the patient three days later—the next time that hæmorrhage occurred. I took with me a nurse and instruments for dilating the uterine canal and for removing the remains of membranes. Her physician, however, felt very positive that none of the membranes had been left in the uterus, and stated that he had examined the placenta very carefully, and that there was no interruption of its continuity whatever. But I felt equally positive that some of the placenta yet remained in the uterus.

When the patient had been placed on the table and the ether-cone applied over her mouth, she suddenly sprang up in a state of wild excitement, and could not be induced to continue the inhalation of the ether, it had affected her so badly when she was operated upon for vaginismus. All means of persuasion were futile, and her friends desired that she should be compelled to take the anæsthetic. But I objected to compulsion, because, under such circumstances, after delivery, I have seen most violent and uncontrollable mania developed. In one instance the mania continued three weeks, during which time the patient was very violent, and had to be watched constantly by a nurse. It is true, the mania seemed to be of an hysterical nature, but, nevertheless, it was very violent. I think we cannot be too careful as to doing that which is strongly opposed to the will of a puerperal woman. I would rather have run the risk of a violent hæmorrhage in this case than have forced the patient to take the ether. She was spoken to kindly and put back into bed, and I assured her husband that she would send for me again within twenty-four hours, to have the operation done.

I was sent for the next day. The patient was then etherized, the uterine canal dilated, the curette was passed, and three pieces of placenta were removed, each as large as the last phalanx of one's index-finger. Very little hæmorrhage was excited by the operation, and I felt that in removing the pieces of placenta I had removed the cause of the hæmorrhage.

The points I wish to make are these. The case was an interesting one: 1st, with regard to the vaginismus; 2nd, with reference to the condition of the veins of the vulva; 3rd, with reference to the danger of giving ether during a state of maniacal excitement; 4th, with reference to what I believe to be the usual cause of delayed puerperal hæmorrhage and the proper means for its cure.

With regard to the statement, so often made, that the placenta has been examined carefully and found entire, it usually amounts to nothing. In the first place, we know that the physician commonly looks at the after-birth hastily and in a careless manner. Besides, I believe that little pieces may be broken off and left behind, which no man could recognize from an examination of the placenta, though he examined it with the utmost care. As in this case, so in all others of delayed puerperal hæmorrhage that I have met with, it has been due to retained placenta or membranes. Dr. M'Clintock mentioned a case in his practice which, I believe, proved fatal. I have met with some which very nearly proved fatal, and doubtless some of those present have encountered similar cases.

TREATMENT OF ACUTE, PULMONARY GANGRENE.

Among the excellent voluntary papers presented at the last meeting of the Illinois State Medical Society, was a contribution to the surgical treatment of acute pulmonary gangrene, by Prof. Christian Fenger, M. D., of Chicago. The paper deserves and will elicit general attention, both from its intrinsic merit and as indicative of progress in American surgery.

As advised at the present time, four operations for acute pulmonary gangrene have been performed.

The first operation was performed in 1879, by Messrs. Lawson and Cayley, of England, in a case of five weeks' standing. Decided amelioration of symptoms, as regards cough, dyspnœa and fetor, was observed. The patient died of exhaustion four days after the operation. The autopsy disclosed facts which led the operators to believe that an earlier operation would have saved the patient's life. (Med. Society, London, 1880.) Mr. Solomon Charles Smith, of Halifax, performed the second operation in 1880. The patient was in the second week of croupous pneumonia, when gangrene occurred in the lower lobe of the left lung. The patient lived ten days, with marked improvement in cough, dyspnœa and fetor. No autopsy was made. Professor Buhl, of Christiana, performed the third operation in 1880. Acute gangrene in the anterior portion of the left lung was the indication for operation. After a long convalescence of six weeks the patient recovered.

The fourth operation was performed by Professor Christian Fenger, of Chicago, in the Cook County Hospital, in April, 1884. The patient, male, 34 years old, was in the second week of croupous pneumonia. Signs of consolidation and formation of a cavity in the right infra-mammary region,

extending into the right axilla, were elicited by auscultation and percussion. Cough was distressing and dyspœna great; about one pint of extremely offensive sputa was daily expectorated. The patient lost all appetite and rapidly progressive emaciation supervened. A cavity was found, upon the introduction of the needle of a hypodermic syringe through the thoracic wall, in the right infra-mammary region. An incision was made parallel to the clavicle; the ribs exsected to an extent sufficient to secure access to the part, and the needle re-introduced within the cavity, as a guide. The cavity was then cut down upon by the small platinum pole of a Paquelin's thermo-cautery, and an opening sufficient to admit the index finger secured. Digital exploration revealed no detached gangrenous masses. Accordingly, the cavity was gently washed out, a drainage tube inserted, and the usual antiseptic dressing applied. Hemorrhage during the operation was trifling, but washing out the cavity produced very troublesome coughing. The patient speedily reacted from the shock of the operation, which was relatively slight. Five hours after the operation, appreciable diminution in the fetor was noted; at the end of the first week, expectoration was minimal, and fetor could not be perceived; at the end of the second week, decided improvement with return of appetite was observed; the fourth week witnessed further progress; and at the end of the fifth week the patient was out of bed. During convalescence bits of gangrenous lung tissue were discharged through the external opening.

With reference to the *technique* of the operation, Dr. Fenger recommends :—

1. The incision ought to be made parallel to the ribs.

2. The ribs must be exsected to a degree sufficient to secure access to the part.

3. In conformity with the suggestion of Albert and Mosler, the needle of a hypodermic syringe should be used as a guide into the cavity, or diseased lung tissue, and the small platinum pole of Paquelin's thermo-cautery should be employed to effect the opening.

4. The cavity must be washed out if practicable. Due care must be exercised to prevent drowning, if the cavity connects with a bronchus. Irrigation of the cavity was productive of no untoward effect in Buhl's case, but was the cause of troublesome cough in Fenger's patient, and Mosler ascribes one death to poisoning from thymol irrigation.

Dr. Fenger is of the opinion that there is no danger of death from the operation, and that it is indicated in cases of acute, circumscribed, pulmonary gangrene.—*Chicago Med. Jour. and Examiner.*

THE USE OF CHLORIDE OF GOLD.

Dr. Bartholow, *(Med. News)*, Aug. 2nd, 1884, says :

From the various sources of information now available, chiefly clinical, we learn that the preparations of gold possess those properties formerly entitled *alterative*, and now usually designated by the phrase *promoting tissue metamorphosis, or metabolism*, and the power to give stability to nervous matter, or the antispasmodic property. There are three several heads under which it will be convenient to group, for my purpose, the therapeutical powers of gold and its preparations, quite irrespective of its supposed physiological actions :

The so-called alterant effects ;
The action on the nervous system ;
The urino-genital properties.

Before undertaking to present the details under these several heads, it may be best to say something of the preparation used. I have always preferred the double chloride of gold and sodium, since I learned how little diffusible the chloride is. Injected subcutaneously in animals, the chloride seems not to diffuse through the vessel-walls, and when introduced into the blood tends to clog the kidneys. On the other hand, the double salt is readily diffusible. I have no experience with metallic gold or the oxide. Notwithstanding the chloride is so little diffusible, when taken into the stomach, effects are produced. It is probable that in the reactions which ensue the double chloride—of gold and sodium—is formed.

The usual dose of the gold and sodium chloride is one-twentieth of a grain. In this quantity twice or three times a day, it appears to have, as its primary action, the power to promote constructive metamorphosis, to improve the globular richness of the blood, and to increase tissue strength. However, kept up for a time, tissue changes become more rapid, and waste occurs in excess of repair. The tissues yielding most readily are, as might be expected, the connective, and especially those of pathological formation. Hence the utility of this remedy in *sclerosis*, whether nervous, hepatic, or renal. Especially in posterior spinal sclerosis, and in chronic interstitial nephritis, have I found the gold salt very efficacious. I am far from believing that lost parts may be restored, although some of my critics appear to think my credulity limitless. If used in locomotor ataxia, early and persistently, it has seemed to arrest the disease. It is true, since the publication of Strumpf's results with the faradic brush, I have not failed to make use of this method, but that it alone will stay the morbid process, I do not find. Before the electric brush had been employed systematically, I had witnessed the best results from gold and sodium chloride. During the last ten years, I have seen many cases in consultation, but of five in my immediate charge which I have followed, and in which the treatment was begun with the onset of the second stage, in three the disease seems not only to be arrested, but the condition improved. The knee-jerk, how-

ever, remains absent or feeble. The others are manifestly improved. Thus far, no persistent gastric or intestinal disorder has been caused by the remedy.

Excellent results have followed the use of the gold chloride in many cases of fibroid kidney, not only in my own hands, but in the care of other practitioners. Unquestionably the homœopathists, guided in the use of this agent by the symptom—increased urinary flow, have had good results from the first dilution, but this topic is foreign to my present purpose.

There is a form of hypochondriasis, coincident with the onset of degenerative changes in the cerebral vessels—and it may be dependent on these changes, in which the gold and sodium chloride is very effective. It must be persistently used, and after a time the uneasiness in the head, the vertiginous and other abnormal sensations subside, the mental depression at the same time clearing up. Dr. Bauduy, of St. Louis, kindly informs me that he has had the same good effects. It seems to me that the ancient notion that gold is a "cordial" to the mind in the cases of melancholy, is also supported by modern experience.

In certain affections characterized by spasm, as asthma, laryngismus stridulus and singultus, this remedy acts surprisingly well sometimes. A physician with large experience in a malady which I do not see at all nowadays—pseudo-croup, or laryngismus—informs me that he employs no other remedy, and his patients get speedy relief. There are various cognate affections in which, no doubt, it will be found in a high degree useful.

The same powers render gold a remedy of great value in certain urino-genital affections. I have referred to chronic interstitial nephritis. I could enumerate many instances of the more chronic cases of albuminuria, in which the curative effects of this remedy have been most conspicuous; but I am here concerned with the merely nervous affections. There are certain cases of sexual debility, accompanied by an extreme degree of hypochondriasis, which are amongst the most difficult and unsatisfactory with which we have to deal. No remedy has seemed to me so serviceable as this in this troublesome condition of things. In simple sexual debility, its administration promotes activity. In dysmenorrhœa with scanty menstruation, and in chronic metritis, accompanied by these symptoms, the persistent administration of gold and sodium chloride has done much good.

LITHOTOMY—LATERAL *vs.* HIGH OPERATION.

Sir Henry Thomson, in his lectures before the College of Surgeons, speaks of these two operations as follows:

There is unquestionably a growing expression of dissatisfaction among surgeons, especially abroad with the lateral operation for stones of unusually large size. I have for some time fully shared that feeling. No incisions can be made in the region which belongs to that operation through which a calculus of three ounces or more can be extracted. Laceration, either avowedly made by instruments or but half concealed under the name of gradual distention, invariably takes place, and that affecting very important structures, often to a large extent. Hence it is that the suprapubic operation has always invited consideration when the stone is exceptionally large; but the conditions sometimes met with, especially in corpulent subjects, have often presented peculiar difficulties and dangers, which indicated that, if Scylla has been avoided above, Charybdis appears to be equally dangerous below. A modification of the operaton, however, has recently taken place—if not originated, at least first executed, by Professor Peterson, of Kiel, and described by him in 1880, which gives a new and improved position to the high operation, The improvement suggested consists in ensuring, to a degree not before attained, the raising of the bladder above the pubic symphysis, and the steadying of it in that position during the operation. These objects are thus attained. The patient, lying on his back, and under the influence of an anæsthetic, the bladder is first distended with weak solution of boracic acid, in quantity from ten to twelve ounces if possible, which must depend on the condition of the organ. The penis is firmly tied; nothing is better than an india-rubber tube for the purpose. Then a pear-shaped bag of india-rubber, tolerably stout, so as to retain that form, and capable of holding at least sixteen ounces of fluid, is folded longitudinally and introduced into the rectum. By the tube which forms its apex, and is supplied with a stopcock, water is forced in so as fully to distend the bag *in situ*. The outline of the bladder will now be traced above the pubic symphysis. The usual vertical incision is made, and dissection carried down to the bladder, with the usual precautions with which we are familiar. The ease and certainty, however, which are ensured by the firm position of the bladder on this system render it much superior to the old one.

I have operated by the high operation twice only, and that before the introduction of the new method. Since that time I have met with no case which I have not been able to deal with satisfactorily by lithotrity at a single sitting, of which several examples are placed before you—the calculi weighing from one to nearly three ounces. The next case which offers for which the knife is required, I shall almost certainly submit to the high operation, with Peterson's modification. And the only reason why I have not yet performed it is, that I have easily and successfully employed

lithotrity in cases precisely similar to those for which the French surgeons are adopting Peterson's procedure.—*British Medical Journal.*

CEREBRAL ABSCESS.—The antiseptic method of operating and after-treatment has not yet been fully tested in operations upon the brain. This is natural, for not only have we inherited a just dread of dealing with an organ, the large majority of whose diseases are dangerous or fatal, but our knowledge of the physiological functions of the brain and of their pathological modifications being extremely limited, we are not in a position to form such an accurate diagnosis as calls for surgical interference. Drs. Christian Fenger and E. W. Lee, of Chicago, in an extremely interesting paper on this subject in the July number of the *Am. Jour. Med. Sciences*, consider the treatment of traumatic cerebral abscess, and report a case which was successfully treated by opening and drainage.

Bergman, in discussing the treatment of cerebral abscess, unhesitatingly sets it down as an axiom that wherever there is an accumulation of pus, trephining is most clearly and indubitably indicated, for the opening of an abscess in the brain is as necessary as in any other part of the body, and we would add even more so. A correct diagnosis of abscess having been made, the further difficulty presents itself of locating it with sufficient accuracy, so as to be able to find it. A number of cases are on record in which a correct diagnosis had been made, the trephine also put on more or less on the right place, but the knife or trocar being passed into the brain nevertheless missed the abscess. Drs. Fenger and Lee show by their case that this difficulty can be obviated by multiple exploratory aspirations, performed at interstices sufficiently small to prevent any abscess from escaping detection, even if the trephine opening should not have been made at the point of the skull nearest the abscess.

There are on record a large number of cases of cerebral abscess in which trephining was performed, pus evacuated, and temporary relief obtained; but later relapse followed, and a fatal termination ensued. It is possible, judging from the success the practice has met with in the treatment of abscesses in other situations, that drainage of the cerebral abscess cavity, with or without washing out, would have saved some of these cases, by preventing the re-accumulation of pus and the continuous infection of the surrounding brain tissue, the acute œdema of which is well known to be, as a rule, the final cause of death. As far as Drs. Fenger and Lee are aware, draining and washing out of cerebral abscess cavities has heretofore not been tried; that it can be effected, and without any detriment to the patient, is shown by their case, the treatment of which they hold strictly conforms to the rational method of modern surgery in treating abscesses in general; and because of this, and not because their patient recovered, they regard the case as answering affirmatively the question: Is it probable that abscesses in the brain can be treated advantageously on the same principle as abscesses in other parts of the body?—*Louisville Med. News.*

TREATMENT OF TAPE-WORM. — In the *Med. Times* of October 11th, 1884, Dr. Bernard Persh writes of the comparative value of the remedies used for the expulsion of the tape-worm. At a western military post a number of the men were troubled with this parasite, the writer being of the number. Turpentine, ether, pomegranate-root, male-fern, kooso, salicylic acid and carbolic acid were tried; and the best results obtained from the use of the last two named. Kooso was given in six drachm doses, suspended in water and followed by one ounce of castor oil. Two grains of carbolic acid were administered in a pill of extract liquorice; if, after a dose of castor oil this treatment failed, it was repeated on the following day. Large doses of carbolic acid may be given without producing disturbance of the digestive organs or carbolic acid poisoning; but in some cases even large doses of the acid failed to expel the worm. Several years after, the writer having been recommended to try croton oil and chloroform as a remedy, did so on himself, and it proved successful where the others had failed. Since that time he has used the treatment on more than twenty cases with excellent results. One drop of croton oil and a drachm of chloroform are suspended in an ounce of glycerine, and administered in the morning before breakfast. The only preparatory treatment consists of a half ounce of Rochelle salts given the preceding evening, which, although not necessary for a cure, facilitates the examination of the evacuations, prevents the breaking of the worm by hard fæces and allows it to pass more quickly through the intestines after becoming detached. The chloroform produces no bad effects; the slight giddiness and drowsiness sometimes noticed was relieved by the recumbent posture and disappeared when the croton oil commenced to operate. The oil acts rapidly, the bowels being moved in about an hour after its administration, and any tendency to diarrhœa or intestinal irritation is readily checked by bismuth and opium after the worm has been expelled. In one case the chloroform alone was efficient in bringing about the expulsion of the worm; but the fact that the worm is always expelled alive, showing that the chloroform, while compelling it to relinquish its hold, is not sufficient to kill it, renders the administration with it of a drastic purgative of rapid action, advisable. The author concludes by stating that in the cases treated successfully in this way, other remedies had been unsuccessfully employed. The patients agreed that

the remedy was readily taken, that its immediate effects were by no means unpleasant, and that the treatment did not leave them prostrated.—*Maryland Med. Journal.*

GLOSSO-LABIAL PARALYSIS.—Modern thought and research drift more and more to the position that the affection described by Duchenne as glosso-labial paralysis, and. long supposed to be distinct, ought to be stricken from the list of diseases. In its typical form it is certainly only a localized chronic poliomeylitis, a mere variety of chronic muscular atrophy, in which the gray portion of the upper segment of the spinal cord—*i. e.*, the medulla oblongata—is especially attacked. It may exist by itself, or it may be associated with symtoms of palsy, due to poliomyelitis, in other parts of the body. In the latter case the medulla may be the first part of the cord invaded, the disease extending downwards, or the lesion may progress upwards and the medulla show the latest change. In a very interesting case recently shown at the clinic of Prof. H. C. Wood, the first symptoms were perceived by the patient in the mouth region, and subsequently the cervical cord became profoundly affected.

To grant these labio-glossal paralyses a separate state in our classification of disease would logically require similar treatment for cases of progressive muscular atrophy in each part of the body, since any spinal region may be attacked alone or separately.

The absurdity of the present separation of glosso-labial palsy is further shown by the circumstance that we may have such paralysis due to various apoplexies, brain-tumours, and other coarse cerebral lesions, and, to be logical, we should also isolate as a distinct disease cerebral glosso-labial paralysis.

In No. 20, *Archives de Neurologie*, is an important paper upon such an affection, by Dr. F. Raymond, in which illustrative cases are cited. The symtoms may, in case the lesion is a tumor, or other progressive alteration of brain-tissue, develop slowly, but they usually come on suddenly, because they are usually the result of clot or other apoplectic lesion, and, while they may develop alone, they are usually associated with other consentaneous palsies. Whether the manifestations come on slowly or rapidly, the cases are to be distinguished from those of medulla-disease by the absence of atrophic changes in the muscles affected, and by the preservation of the normal electrical reactions. The symptoms are stationary or progressive, as the case may be, *pari passu* with the cerebral lesion. The latter is either cortical or in the white matter. The general localization of the lesion of the white matter is in the lenticular nucleus or the external capsule, or sometimes in the internal capsule or peduncle. The foot of the ascending frontal convolution is stated to be the position in which cortical lesions cause the glosso-labial palsies.—*Medical Times.*

CHRONIC BRIGHT'S DISEASE.—Dr. Hiram Corson, Conshohocken, Pa., in a recent communication to the *Medical Times*, says: That a farmer, 46 years of age, complained for several months of ailments not uncommon in the beginning of Bright's disease, and finally sent for a physician, who finding his urine to be very albuminous, put him under the use of the various medicines recommended in that affection. Months passed; the limbs began to swell, and the anasarca was over the whole body. All the usual remedies of the day were applied, but with only the effect of temporary relief at times, to be followed by aggravation of the symptoms. When he was in this deplorable condition I remembered case upon case seen forty or fifty years ago, much like this, and proposed that we try the old plan. So we began to give, in pills, one grain of calomel, one of digitalis, and one of squill, three times a day, morphia or chloral, one or both, at night, to relieve oppression and induce sleep. Day after day we went on for two weeks, before the breath announced that the system was effected by the calomel, and all this time there had been no perceptible change save an increase in quantity of urine. But then all the symptoms showed an amelioration. The medicine was then used or omitted as seemed indicated. The object was to keep the system moderately under the influence of the mercury (what an awful word!) but not to push it to heavy salivation (another awful word!) From that time, every day showed an improvement—a rapid improvement—in the symptoms. Now, that is just what I will do for the first advanced case of Bright's disease that may come under my care.

HÆMORRHOIDS OPERATED ON WHEN INFLAMED.—Before the Kentucky State Medical Society at its recent session, held at Bowling Green, Prof. J. M. Mathews, of Louisville, addressing himself to this question, said:

"From a variety of causes, piles are liable to become inflamed, and once inflamed, they may easily become strangulated by passage below the sphincter. Everything is aggravated in this condition and it may take some weeks to quiet the trouble. It has occurred to me, why not operate upon and get rid of them at once? There is no authority that says "operate upon a pile during the inflamed state," but they will tell you to apply treatment to reduce the inflammation. I want to state one or two cases. A few weeks ago, I was called to a lawyer who was in this condition. The family physician in attendance had tried in vain to quiet inflammatory action, for two or three weeks. I found, hanging down from the anus, two solid

tumors; I passed the knife around them and ligated them. I visited him the following morning, expecting to find him in some trouble. To my satisfaction, he was out of the house in one week's time. Another case: A young man had a mass of inflamed tumors, hanging from him, larger than my fist. It would have taken several weeks to abate the inflammatory trouble and I ligated the whole mass. I went to see him next morning. I was told by the people at the house, that he had rested well all night, and got up early in the morning and went out. They sent for him but he could not be found. Three days later, I received a postal from Cairo, Illinois, saying that he was that far on his way home and was all right. When he got home he wrote me that he was entirely well; since then, I have had, I suppose, five or six cases of similar character, in which the proceedings and results were similar. I have, therefore, concluded that instead of applying remedies to relieve the inflammation in the tumors, they should be operated on at once."—*Am. Practitoner.*

THE TREATMENT OF SPRAIN BY THE ELASTIC BANDAGE.—This method of treating sprains has recently been recommended by Marc See *(Revue de Thérap.)*. It is the only method which fulfils the two indications: 1. To cause as rapid absorption as possible of the blood extravasated around the joint (a lesion which controls all the other symptoms, such as pain, swelling, difficulty of movement, etc.); and, 2. To favor cicatrization of the torn ligaments and ruptured parts by complete immobilization.

The antiphlogistics and blood-letting, formerly advised by Hunter and Guersant, only partially fulfil the former indication. There is the same objection to the movements which Ribe and Bonnet advise for the injured joint. The refrigerants and cold-water baths advised by Baudens cause contraction of the tissues around the joint, and dispel inflammation, but they are not favorable to the absorption of the infiltrated fluids. Even massage, though superior to the other remedies just mentioned, fulfils only the second indication; furthermore, it is inconvenient, and requires much patience and time; and between the seances of manipulation the swelling reappears and the pain returns. It is true that masssage has the advantage of removing the extravasated materials from the region of the joint toward the more vascular portions of the limb, where they are more easily absorbed. But the elastic bandage has this advantage in a greater degree, since its action is continuous. Finally, and above all, it favors immobilization of the joint, which is impossible during massage, and without which it is almost impossible to get cicatrization of the torn structures and complete recovery in sprains of any intensity. The bandage should be applied to the skin itself, care being taken to fill up the flat and depressed places with wadding, so as to give a uniform surface around the joint for the bandage to act upon.—*Medical News.*

CHRYSOPHANIC ACID IN SKIN DISEASES.—Dr. Stocquart reports sixty-one cases treated by internal administration of chrysophanic acid *(Annales de Derm. et de Syph.*, Jan. 1884*)*. No form of local treatment was employed. Of the sixty-one cases, fifty-six were entirely cured, and only one was unaffected by the treatment. The cases of acne, ecthyma, and impetigo, all yielded rapidly to the treatment, except one case of papulous acne. One case of pityriasis and three of urticaria were also quickly cured. In four cases of lichen and four of prurigo, the irritation was rapidly diminished, disappearing before the complete cessation of the eruption in lichen. Of thirty-two cases of eczema, thirty were cured. The author was struck with the rapid and complete cure of acute eczema and of impetiginous eczema in children. Out of five cases of psoriasis, three were cured. The acid was generally administered in water, the bottle being well shaken before use. In ordinary doses no patient objected to it; it was also prescribed in pills. The medium dose is one centigramme a day for children, and three centigrammes for adults. In these doses it is generally well tolerated; in large doses it may cause loss of appetite, nausea, palpitation, with præcordial distress and constriction of epigastrium, giddiness, vomiting, and cold shivers. This is an occasional occurrence only, and often much larger doses are well borne. Children tolerate the medicine well; at four weeks, he has given one, two, and in one case five centigrammes without provoking gastric irritation. Where the eruption is limited to parts ordinarily covered, and when the skin is not very thin or delicate, the external use of chrysophanic acid as an ointment is indicated. Where a great extent of surface is involved, the internal use is better. Phenomena of local irritation, or erysipelas, or, gastro-enteric symptoms, or nephritis, may be caused by the too free external use of the acid. Its internal use is also indicated when the eruption affects the hands or face. Where the stomach will not bear the remedy, it may be given hypodermically; but is then apt to cause pain and abscess. Its action is more rapid than when given by the mouth.—*N. Y. Med. Four.*

A MEDIEVAL RELIC.—At the recent meeting of the American Gynecological Association, Dr. T. Gaillard Thomas showed and made some interesting remarks about a medieval relic which had recently come into his possession. He had spent the past summer in a little, out-of-the-way Long Island village.

A friend in this village had recently received as a bequest, from France, some thirty large, old-fashioned trunks. These trunks contained old

MSS., books, jewelry, dresses, and odds and ends of all descriptions. In one of the trunks a very peculiar harness, which puzzled the gentleman, was found. It was submitted to Dr. Thomas. Upon examination, it was found to consist of a jointed steel girdle, covered with velvet—intended to encircle the waist of the wearer—and a semicircular rod of solid steel, with two circumscribed dilatations, joining the circular girdle at right angles. It was evidently meant to be employed in the same way, though for a different purpose, as the female T bandage. The diamond-shaped dilatation, intended to fit accurately the vulvar orifice, was guarded upon both sides, on the inner edge with sharp steel teeth, pointing downward, forward, and outward. The circular ring designed for the anal orifice was provided with steel teeth in an identical manner. Armorial bearings were discovered upon different portions of the harness. Behind, at the point of junction of the girdle with the perineal rod, was the place for a lock, or rather seal. The diagnosis was plain. It was a *ceinture*, similar in shape and design to the girdle of *Diana de Poitiers*, which every one who visits Paris sees in the *Musée de Cluny*. The Crusaders were evidently in the habit of locking up home effects before their departure to the wars.—*Louisville Med. News.*

Cancer of the Cervix Uteri.—Dr. Goodell gives the following method of treatment in the *Med. and Surgical Reporter*—"Having torn away all I can with my fingers, I inject pure vinegar, and now resort to the serrated curettes. With these the parts are thoroughly scraped, and with the gouge-forceps the vaginal portion of the cervix is removed. Next, with the platinum buttons of the thermo-cautery, I char the whole funnel-shaped wound. * * * The operation is now ended, and as there is no hemorrhage, I shall not tampon the vagina. But supposing you operate in the country at a distance from home, and you wish to guard against hemorrhage, or to stop an oozing, what do you do? You take a sponge and pass a string through the centre and tie the two free ends together in a long loop. Do not tie your string around your sponge, for you will then deprive it of its elasticity and the power of expanding. Prepare three sponges in this way, and soak them in vinegar. Pack the first sponge very firmly into the funnel-shaped wound, and make one knot in its string. The second sponge, with two knots in its string, will be pushed down to the cervix; and the third one, with three knots, will keep the other two in place. In twenty-four hours remove the sponge with three knots, and in forty-eight hours withdraw the sponge with two knots, and immediately afterwards the sponge with one knot. This last one must be removed carefully, and with a rotary motion. I do not put sponges in my patient's vagina because she is in a hospital, in which some physician is always on hand. But supposing at 3 o'clock this afternoon the nurse finds our patient bleeding, what instructions shall I give our resident? He will first inject vinegar, and if that does not stop the hemorrhage, he will then pack the womb and vagina with sponges in the way which I have just described."

The Medicines Physicians Use.—Squibb's Ephemeris gives an analysis, containing some points of interest of some observations made by Dr. Wm. P. Bolles on the prescriptions which he found on the files of three Boston pharmacists. The number counted was 3,726 which were pretty generally from physicians of that city. The number of articles entering these prescriptions was 504, the whole number contained in the U. S. P. for 1880 being 994. Of the 504, 236 occurred 5 or more times; 157, 10 times; 80, 25 times; 27, 50 times 9, 100 times; 1, 200 times. Sulphate of quinine leads the list, and is found in 292 of the 3,726 prescriptions; sulphate of morphine in 172; bromide of potassium in 171; iodide of potassium in 155; tincture of chloride of iron, 134; subnitrate of bismuth, 133; glycerine and syrup together, 120; syrup, 108; carbolic acid, 92; extract nux vomica, 87; paregoric, 80; bicarbonate of soda, 77; calomel, 72; chlorate of potassium, 71; compound tincture of gentian. 67; lime water, 65; and so on down It will thus be seen that of the 994 articles of the Pharmacopœia, only 18 occur more than 65 times in 3,726 prescriptions, and of these 18 three are vehicles or adjuncts which are in such common use as to bring their numbers into prominence. Dr. Squibb regards it as surplusage of a very useless kind to have a drug in substance, in *abstract decoction, infusion, extract, fluid extract*, and *tincture*. He says the individual habits of physicians are the cause of much of this surplusage. One of the remedies for this evil he points out as follows:—"The individual preferences of physicians are largely prejudices adopted from teachers in the schools, and, therefore, if the schools would but reason upon the subject, and direct only the best preparation of each drug, a needed reform in the Pharmacopœia would soon follow, and the pharmacists' supplies would be much fresher and more trustworthy.—*Med. Age.*

Placenta Prævia.—Prof. Parvin (*Col. & Clin. Record*) says:—While there is no single plan of treatment applicable to all cases of placenta prævia, in general, this treatment may be comprehended in the alliterative phrase, Temporize, tampon, turn. Temporize if the hemorrhage be not so great, and the pregnancy not near its end. Tampon if the hemorrhage be severe, and the os not sufficiently dilated for immediate delivery; but let the tampon be so applied that the hemorrhage will

be surely stopped and that dilatation of the os may be effected. Of course, a tampon can be most effectually applied if the perineum be drawn back by a Sims' speculum, and the os can be best dilated by a sponge-tent, or by means of Barnes' dilators, and these are to be preferred. If you use a vaginal tampon, do not soak the material in any astringent solution, for it is not by coagulating blood, but by pressure, you hope to arrest the flow. Of course, position is important, and you may also give cold acid drinks; opium and stimulants may be required if there be pain and prostration. Finally, turn—turn, because very often in placenta prævia the fœtus is transverse; turn, because when you bring the legs and then the thighs into the os uteri, you have a most effectual tampon; turn, because you can thus as a rule most quickly effect delivery; and the great dominating principle in the treatment of placenta prævia is, that when the hemorrhage is grave, end the pregnancy as soon as possible, both for the safety of the mother, and the safety of the child.

MORPHINE IN THE EARLY STAGES OF INSANITY.—The responsibility of the physician in the use of morphia, in consequence of the possible development of the morphia habit, is great; but his responsibility relative to the possible disaster of a preventable life-long insanity, not prevented, is, if possible, still greater.

Auguste Voisin, of the *Salpètrière*, Paris, claims for the use of the hydrochlorate of morphia, in gradually increased large doses long maintained, remarkable results in the treatment of certain forms of insanity. His theories are well sustained by physiological observations, and his cases are taken from the records of the *Salpètrière* and private practice, and many of the cases have been examined after the lapse of several years.

In the article referred to, "Leçon Trentième," he gives a resumé of the history of the systematic use of opium and morphia in the treatment of insanity, and dates his own experience with it from the year 1867. His success was at first greatly diminished by the obstinate vomiting which frequently occurs; but on learning from M. Roller, Physician of the Insane Asylum at Illenau, France, that, regardless of the vomiting, the dose should be increased, he continued to increase the dose, and to that instruction he attributes his success. He has since treated successfully the various manifestations of insanity, which would seem to correspond practically to the first division adopted by the International Congress of Alienists in 1867, namely: simple insanity, comprehending mania, melancholia, monomania, circular insanity, moral insanity, in their early manifestations.

He uses exclusively the hydrochlorate of morphia, and only hypodermically, but fails to give the strength of the solution which he finds most satisfactory. He does not mention the combination, so much appreciated in America, of morphia and atropia. Probably the association of the atropia is not to be desired. The efficacious dose desirable to sustain until the desired effect is obtained, can only be found by proceeding cautiously and studying each individual apart. One rule which the author never departs from, is not to exceed, in the initial dose, from one to three milligrammes. Whilst light cases associated with hallucinations are frequently relieved in a few days with a daily dose of from five to six centigrammes, yet in other cases the dose has to be increased to seventy centigrammes. He narrates one case in which two grammes of the hydrochlorate of morphia, in two doses, were administered daily, with no manifestation of its presence beyond a contraction of the pupils. The latter was one of the unsuccessful cases. He never entrusts the administration to a nurse.—*Jour. Am. Med. Assoc.*

IS PAIN DURING THE FIRST STAGES OF LABOR NECESSARY?—In a communication to the *Obstetric Gazette*, Dr. I. W. Chisholm says that in answering this question I would say, from my own experience, and also from the observation of others with whom I have conversed on the subject, I have concluded that the pains incident to dilatation of the os during the first stage of labor are not necessary. My attention was first directed to this some years ago. Being called to see Mrs. G., whom I found suffering from the pains of the first stage of labor, being of the grinding character, and seemingly at regular intervals, I found, upon examination a rigid os and no signs of dilatation, and after waiting a considerable while I made another examination and found the same condition of things. I then concluded the pains were probably of the spurious kind, despite their seeming regularity, and gave her a dose of morphia, and in a short time she was entirely relieved and I took my departure. About ten o'clock in the evening I concluded I would call and see her before retiring, and on entering I found her resting comfortably, as she had been ever since I left in the morning after administering the morphia. I made an examination and found the os well dilated. I remained, and in a short time the second stage of labor came on, and the child was born in a few hours.

I was attending on Dr. P. at that time, and on calling on him in the morning I reported the results of my observations, he being a man of a large and extended experience of thirty-five years, said that he also had noticed the same thing, and always attended by good recoveries. Now if this is the experience of all who have tried it, why not relieve women of the painful ordeal of the first stage of labor?

A PIN SLING.—Samson Gamgee F.R.S.E., of

Birmingham, gives the following in the *Lancet*, Sept. 27th, 1884: A gentleman consulted me the other day, for a painful condition of the tip of his left little finger. To secure the benefits of physiological position and immobility, I bent the elbow at an acute angle and raised the hand; then, pinching up the sleeve at the wrist, fixed it to the coat with a safety-pin; with another I attached a fold of the sleeve to the coat just under the elbow. Rest was absolute; the finger waxed pale and easy; and my patient went to his office duties in comparative comfort.

Even if an ordinary sling be at hand, the process of fixing the forearm at an acute angle is not quite simple; and the resulting unsightliness is often unpleasant. With a little contrivance a pin sling may be made invisible. A third pin, fixing the inside of the arm sleeve to the body of the coat, adds greatly to immobility. In this position I have found one pin very useful, in steadying the shoulder of a young lady who had had it dislocated three times. She had barely recovered the last accident, when she was very anxious to go to a ball. By fixing, with a safety-pin, the inside of the sleeve to the bodice, a trusty yet invisible, checkmate was provided, allowing freedom of hand, but barring abduction. These are trifles, only noted apologetically, because, *pro re nata*, they may be useful.

CHLORATE OF POTASH IN TINEA.—Dr. C. C. P. Clark once had a case of tinea tarsi in a little girl. In spite of all the treatment recommended in the books, the morbid condition of the Meibomian glands persisted in pouring out their sticky exudation. Considering its efficacy when internally exhibited as an alterative in certain affections of the mucous membranes, particularly of the mouth and throat, the patient was given full doses of this medicine—about a drachm per diem. It worked like a charm. Repeatedly the disease returned, as is its wont, and was as often and as readily subdued. He has since constantly used this medicine in that complaint, and has never been disappointed.

Not long after a lad was brought to the doctor whose scalp was thickly bossed with huge, stinking, porriginous scabs. Reasoning from what was seen in the last-mentioned case, the same remedy was used to stay the morbid secretion in this, and with like good effect. The crusty hummocks disappeared, as a syphilitic node sometimes will under the use of the iodide of potassium, only far more rapidly. He who tries this remedy in this disease, in full doses, will not turn again to the scalp-shaving, poulticing, etc., which is the customary practice.—*N. Y. Medical Journal.*

THE HYPODERMIC INJECTION OF PILES.—Dr. J. W. Girard, of Winchester, Tenn., says "that the use of carbolic acid in hemorrhoids is condemned by the majority of leading physicians, but successfully used by non-professional men." He further asks if there is not something radically wrong in the method of using the remedy, or in the act of condemning it, and continues: "If my experience with the use of the hypodermic syringe in hemorrhoids is worth anything to the profession I give it cheerfully.

"I have used it for about ten years, and have treated, I think, about two hundred cases without a single failure, and in no case has the tumor returned thus far. My course of treatment is generally to take one part of tannic acid, two parts of carbolic acid, four parts of alcohol, and eight parts glycerine. Inject each pile separately, and in a few days they slough away and generally heal kindly under dressings of carbolated cerate. If there is much constitutional disturbance, I generally control it with a steam bath or a hot sitz bath. My confidence in the method is so strong that I would persist in its use in spite of all that could be said against it. I would gladly answer any questions in my power that would enlighten any professional brother on the subject."—*Medical Bulletin.*

"TAKE YOUR FORCEPS WITH YOU."—Dr. H. V. Sweringen, of Fort Wayne, Ind. (who is well-known to our readers), contributes an article with this caption to the July number of the *Obstetric Gazette*, for the purpose of warning all physicians to be very particular always to carry with them to every labor case their forceps. It is well to issue such a warning occasionally, because on account of the very large proportion of cases of parturition that terminate spontaneously, the physician is very apt to leave his forceps at home, feeling that the chances are against his being obliged to use them, and if his home is far from his patient, and the demand for instrumental interference becomes very urgent, the patient may die before the forceps can be procured. Such a case has happened to Dr. S., and he concludes his article by saying, "I verily believe, that if she had been delivered *promptly*, with the forceps, immediately upon or before the appearance of her first convulsion, her life would have been saved. I close as I began, *take your forceps with you always.*"—*Med. & Surg. Reporter.*

TREATMENT OF NASAL POLYPI.—As a valuable contribution to the therapeutics of this unpleasant condition, we are glad to note that Dr. Richardson, in the *Asclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. This cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient

can expel the whole mass of destroyed polypus, in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Ibid.*

USES OF MURIATE OF AMMONIA.—The *Med. Record* says: It increase the secretion of mucous from the alimentary canal, and is supposed to render the blood less plastic and coagulable, without impairing the structure of the corpuscles. Its habitual use causes emaciation, renders all the secretions freer and more abundant, and exerts an alterative and absorbent action, especially on the connective tissues, in hyperplasia and cirrhosis of many organs. It has even exerted some beneficial influence upon fibrous tumors of the uterus, and much more upon chronic engorgement of that organ. Its slow but steady modification of the nutrition of the connective tissues has been seen in chronic enlargements of the liver, spleen, prostate, thyroid and other enlargements. It cures many cases of gleet and if any internal remedy will relieve strictures of the urethra, this is the one most apt to do it. It cures some cases of neuralgia depending upon thickening of the neurilemma, and is one of the best remedies in fibrous phthisis. If other remedies fail, it should be tried in sclerosis of the cord and brain depending upon thickening and induration of the neuroglia.

MEMBRANOUS CROUP.—Dr. Jacobi says (*Med. News*) the mercurial treatment of membranous croup promises good results. The bichloride appears to be the best preparation for this purpose. The remedy should be given early and frequently repeated. The bichloride should be well diluted (about 1 to 3000). To babies about half a grain should be given in twenty-four hours, and, as a rule, its administration could be kept up for many days, if necessary, without bad effects. Stomatitis or salivation is very rarely observed, and gastro-intestinal disturbances are not frequent under its use. If any unpleasant consequences result from the bichloride, inunction by the oleate of mercury is advised in its place. If the treatment of the diphtheritic disease be undertaken in time, the croup may often be prevented, as this is believed to be due to descending pharyngeal diphtheria.

HYSTERIA WITH UNILATERAL SWELLING.—Dr. S. Weir Mitchell records in the July number of *The Amer. Journal of the Medical Sciences* three cases of hysteria in which there was unilateral increase in bulk at or near the menstrual period, and also at other seasons after emotional excitement, and he has been unable to find elsewhere any narration of similar cases. The writer cannot explain the causes of this phenomenon further than to say that they are under the influence of the nervous system, and vary with the causes which also increase or lessen the analgesia or give rise to chronic spasm. Most probably, he thinks, in many unilateral hysteric palsies a like phenomenon exists, and has merely escaped attention because of being the least prominent in a group of symptoms. At all events it adds another to the large group of resemblances which so closely relate organic to hysteric hemipalsy.—*Boston Med. Journal.*

BLISTERS AND SALICYLIC ACID IN RHEUMATISM.—The following are a couple of brief extracts from a clinical lecture delivered by Prof. Draper at the New York Hospital (*Med. & Surg. Rep.*):

Now a word about the use of blisters in the treatment of inflammatory rheumatism. We do not very often resort to them in acute cases of inflammatory rheumatism where there is a high temperature and great tenderness and swelling of the joints. And in my experience, they are not nearly so valuable here as in cases of sub-acute rheumatism. But where they are used in the very acute cases, it is almost invariably in connection with some other anti-rheumatic treatment, so that we do not get, I think, a true estimate of their value. But in those sub-acute cases where there is a moderate amount of infusion into the synovial cavities and some thickening of the tissues surrounding the joints, I believe that rest of the part and the local application of a blister are very valuable—while in cases of acute inflammation of the joints, I do not believe that blood-letting and counter-irritation are of much value.

There is one remark I wish to make about the salicylic acid treatment of rheumatism. I have told you before that of all the remedies which have been suggested for the cure of rheumatism, and their name is legion, none have given such satisfactory results or proven so valuable as salicylic acid. Now the history of the treatment of rheumatism constitutes a very remarkable chapter in the history of therapeutics.

There is no disease for which a greater diversity of remedies has been proposed. At one time acids were in favor, and at another time alkalies; at one time purgation was practised, and at another opium was used; and salts of every variety have at different times been supposed to have some superiority in the treatment of this disease. As a result, skeptics have arisen who doubt the efficacy of any treatment at all in rheumatism. So about fifteen years ago, at the time of the introduction of Fuller's alkaline treatment, Drs. Gull and Sutton treated a number of cases with simple mint-water, and their

results were as good as were obtained with the alkalies. They believed that all cases ran a regular course, and all had a tendency to end in a week or nine days, or in a fort-night, or else in the classical period of six weeks. But when you come to the salicylic acid treatment, there is no question as to its power. When you see, as we frequently do here, the greatest relief produced within twenty-four hours by the administration of ten-grain doses every two hours, and you find at the same time a great improvement in the appearance of the joints, I think that we get here not only a "post hoc" but a "propter hoc" argument to justify us in attributing the improvement to the use of salicylic acid.

OSTEOTOMY FOR GENU VALGUM. — Osteotomy for genu valgum was discussed at the International Medical Congress, and Macewen's supracondyloid osteotomy was acknowledged by all to be the most satisfactory one. Professor Ogston gracefully acknowledged that his own operation (fracture of the internal condyle) did not yield as good results as Macewen's simpler and safer operation. Professor Schede said that, with German surgeons, he had accepted Macewen's operation as the best. He differed from Dr. Macewen in doing his operation in one respect—he did not use but one chisel, and considered the withdrawal of the instrument from the wound a serious matter, in that it led to an unnecessary disturbance of the parts, and frequently some difficulty occurred in reintroducing the chisel. He thought that in many cases the tibia, rather than the femur, was involved, and in these cases he preferred his own operation (section of the tibia). Mr. Bryant complimented the gentlemen on the manner in which they had given up their pet operations, and had accorded to the supracondyloid operation (Macewen's) its just value.

INTRA-CAPSULAR FRACTURE OF THE FEMUR.—Dr. W. M. Fuqua is of the opinion that the "do nothing" plan of the older surgeons, in these cases, is wrong, and should be abandoned. Experience has shown that bony union can be had, and he thinks that every effort should be made to bring it about. He is satisfied that many of these fractures are through the inter-trochanteric lines, and therefore amenable to the reproductive influence of the periosteum. In the *American Practitioner* for October, 1884, he relates a case where, after ten or fifteen days' confinement to bed, he adjusted a well-fitting "*Sayre's short splint*," and placed the patient on his feet, having first lengthened the sound leg by the addition of an inch cork sole. With this appliance, and a crutch and cane, the patient walks about just as in a case of chronic disease of the coxo-femoral articulation. If the tendency to eversion, or possibly to inversion, be great, then "*Sayre's long splint*" would be required, night extension to be made by weight, and the splint to be used during the day.—*Med. and Surg. Reporter.*

REDUCTION OF SUBCORACOID DISLOCATIONS.—Reduction of subcoracoid dislocations, as directed by Kocher. is accomplished as follows: Patient, sitting up, the forearm is fixed to a right angle with the arm, the elbow pressed firmly to the side of the chest; the arm rotated outward until firm resistance is met with; then the arm rotated inward. The last movement is one of restitution, and carries the shoulder opposite the one dislocated. These manipulations resolve themselves practically into two movements—outward rotation and flexion. Dr. C. A. Jersey (*New York Medical Jour.*, December 8, 1883). says the advantages of the method are:

1. The control obtained over the humerus by the position of the forearm.
2. The advantage obtained by the relaxation of the edges of the rent in the capsular ligament.
3. The absence of the necessity for the employment of an anesthetic.
4. The absence of pain to the patient and of discomfort to both surgeon and patient as compared with other methods.—*Medical Herald.*

TREATMENT OF BOILS.—Dr. John Aulde, following the suggestions of Dr. Sidney Ringer, has met with most satisfactory results by adopting the following plan. The diet is to be regulated and if constipation exists, a teaspoonful of magnesia sulph. in a glass of cold water should be taken every morning before breakfast:

℞ Calcii sulphidi . . . . . grs. iij.
Sacch. lactis . . . . . grs. xxx.
Misce bene et div. in chart., No. xxx.
Sig. Five powders daily at intervals, between meals.

By this method beginning boils will be aborted, and those far enough advanced to threaten a siege of several weeks and successive crops, will soften and heal in such short time that the patient will be surprised at the result. When they can be obtained, granules containing one-tenth grain are to be preferred to the powders. The urine should be examined for sugar, as boils and diabetes often go together.—*Summary.*

GUMMA OF THE BREAST.—Prof. S. W. Gross, says the *Medical Bulletin* (August), brought a case of gumma of the breast before the class last season, which was interesting, both because of the infrequency of its occurence, and of its resemblance to malignant disease. Gumma of other parts of the body are met with almost every day in hospital practice, but it is extremely uncommon to find this manifestation of the syphilitic poison on the female breast. The patient, who was twenty-eight years old, and appeared to be in good health, complained

of trouble in the left breast. Examination showed a cake-like superficial tumor, involving the skin and subcutaneous connective tissue. The skin over the tumor was livid in color, and the nipple was retracted into it. These signs apparently pointed to superficial scirrhus. But from the absence of pain and axillary involvement, as well as the history of a dissolute husband and three miscarriages, Professor Gross concluded that it was a gumma. The woman was put on the mixed specific treatment, and the tumor disappeared in a short time.

LIVER SPOTS.—In an article on tinea versicolor, or liver spots, the *Med. and Surg. Reporter* says: The treatment is not difficult. The sulphur preparations are all useful, such as sodium hyposulphite, one drachm to the ounce of water, or Velminckx's solution, which is prepared as follows: Quicklime, one half ounce; flowers of sulphur, one ounce; water, ten ounces. Boil down to six ounces and filter. Perfume with oil of anise. This may be used diluted with four to eight parts of water, to be dabbed on the patches after a bath with soap and water. At the end of a week scarcely any sign of the disease will remain, and at the end of two weeks a cure may be effected. The result depends largely on the manner of making the application.

EXTIRPATION OF GOITRE BY MEANS OF THE ELASTIC LIGATURE.—Dr. S. Usiglio (*Gaz. de Asp*), reports the case of a patient, æt. 56, who had enlargement of the thyroid body due to hyperplasia of the left lobe, in which the enlargement was removed by means of the elastic ligature. The part came away in five days and the patient recovered easily. Two months previously, in March, 1883, Dr. G. B. Masta had successfully employed the same means for the removal of a pedunculated tumor. De Vecchi and Castelleone have also reported cases. An incision is made into the skin in which the ligature is placed, the wound being disinfected and the ligature tightened daily.—*Practitioner.*

IN-GROWING NAIL.—In a note to the *Union Medicale*, June 26, M. Monod states that during the last twenty years he has treated in-growing nails by a very simple and effectual method, which does not involve the removal of the nail. He makes a free application of nitrate of silver at the commencement of the affection, without isolating the nail. If the cauterization is carried deeply into the diseased furrow, the patient has usually, even by the next day, derived considerable relief, and is able, even thus early, to walk in moderation with an easy shoe. Extirpation of the nail should be reserved for quite exceptional cases.—*Kansas City Medical Record.*

POSITION IN THE AFTER-TREATMENT OF LITHOTOMY.—Alex. Faulkner, of H. M. Indian Med. Service, says:

"I should like to bring to notice a point in the treatment of cases subsequent to the operation of lateral lithotomy, which I have practised for some time, namely, the advisability of continually keeping the patient lying on his abdomen after the operation. Although this mere position may seem at first an apparently trivial detail, yet I consider it is of importance in expediting the healing process of the perineal wound, as by its means the urine has a tendency to pass more through its natural course into the urethra when expelled from the bladder, instead of continually permeating through, and, consequently, irritating the open perineal wound."—*Med. Review.*

DR. J. A. LARRABEE, Prof. of Diseases of Children and Materia Medica and Therapeutics, Hospital College of Medicine, Louisville, Kentucky, says: Bromidia I regard as a more elegant and acceptable mode of administering safe and effectual hypnotics in childhood, than extemporaneous prescriptions. I have no doubt that Bromidia has supplied a want felt by many practitioners in diseases of infancy and childhood, preventing many from yielding to the temptation to use the various preparations of opium, which are so objectionable and dangerous.

INTESTINAL HEMORRHAGE IN TYPHOID FEVER.—At a recent clinical lecture, Professor Da Costa exhibited specimens from a case of typhoid fever in which death had occurred from peritonitis, with three recent perforations of the bowel. The patient four days before his death had had a profuse intestinal hemorrhage. The distinguished teacher took the opportunity of endorsing the ergot treatment of the hemorrhage, but insisted upon the importance of following it up with decided doses of opium in order to prevent perforation or to limit its effects.

OLEATE OF BISMUTH IN ECZEMA.—

℞	Bismuthi oxid,	ʒ j.	
	Acidi Oleici,	ʒ j.	
	Ceræ albæ,	ʒ iij.	
	Vaseline,	ʒ ix.	
	Ol. rosæ	m ij.	M.

Its action is particularly satisfactory in eczema of the hands.—*Von Harlingen in Philadelphia Medical Times.*

A medical student gave the following translation of the very correct Latin adage: "De mortuis nil nisi bonum": "From the dead nothing but bones." He was, probably, cousin-German to the young man who, in answer to a question declared Virchow to be the discoverer of vaccination.

THE CANADA LANCET.

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☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MARLER, 28 Rue Richer, Paris.

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The LANCET *has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

THE PAST YEAR.

As is our custom at this season of the year we present our readers with a short *resumé* of the progress of medicine and some of the principal events which have transpired in the medical world during the past year. This we find, from the wide scope of the work, even in the necessarily imperfect manner in which it is done, to be no easy task, and we would gladly be relieved from the labor if we had the slightest reason to believe that it was not appreciated by the majority of our readers. The ceaseless activity in all departments of medicine renders it very difficult to follow with a critical eye all the new theories, methods, and appliances which have been advanced by enthusiastic admirers, yet there are a few prominent features connected with the progress of medicine, surgery, obstetrics and gynæcology which it may be well to call attention to. Of all departments of medicine probably none have made more rapid strides than public hygiene. The subject is being continually pressed upon the attention of the governments both at home and abroad. Sanitary associations are being formed under favorable auspices, sanitary laws enacted, and govermental aid granted for the purpose of advancing the spread of knowledge among the people on subjects of the highest importance to their well-being. At no period in the world's history has greater attention been paid to sanitary science than at the present time. All this is the outcome of the teachings and repeated admonitions of the medical profession, which is ever in the vanguard of all mental, social and physical improvement in the condition of the people; and in return for this we hope some day to see the claims of the profession more fully recognized and appreciated both by nations and individuals than they are at present. As a sign of the times, and as an earnest of the good things in store for the profession, we may mention the munificent gift of $500,000 to the College of Physicians and Surgeons of New York by W. H. Vanderbilt, Esq.

In the elucidation of questions in etiology and pathology, great strides have been made. Close upon the heels of the discovery by Koch of the tubercle bacillus, comes the announcement of the comma bacillus by the same observer as the cause of cholera, and although there are those who are not prepared to accept all Koch says about these bacilli, he has not as yet been shown to be wrong in his conclusions. Other commissions have been appointed and we shall look forward to their reports with considerable interest. Pasteur's vaccination experiments, too, in connection with hydrophobia, have been put to the test with the most gratifying results, and from these small beginnings who shall say what grand results may be anticidated?

In medicine and therapeutics much valuable work has been accomplished. The use of convallaria maialis in heart disease has been more fully tested, and while the administration of the tincture in five minim doses has been attended with beneficial results in many cases, yet it requires, according to the experience of Dr. Herschell, care in the selection of cases. In one case in which he exhibited it in cardiac weakness and irregularity, the pulse became almost imperceptible, and there was great oppression, whereas digitalis caused rapid improvement in the patient's condition. Intra-peritoneal injections of albuminate of iron in cases of obstinate chronic anæmia have been recommended by Vachetta. He made numerous experiments on animals and never observed the least peritonitis as a result of the operation, and he regards it as safer than Ponfick's intra-peritoneal injection of blood. He recommends one to two grammes (15 to 30 grs.) of the albuminate of the Ammonio-citrate of iron dissolved in warm distilled water and injected through the abdominal wall near the umbilicus. Dr. B. W. Richardson (*Med.*

Times and Gazette) also advises *intra peritoneal* and intra-venous injections of warm saline solutions in the second stage of cholera. Kairine, so highly spoken of as an antipyretic, has on further trial failed to confirm the high estimate formed. Besides, it is expensive, disagreeable to the taste, and transitory in its action. The use of corrosive sublimate in diphtheria has been attended with very good results. It may be administered in doses of $\frac{1}{30}$ to $\frac{1}{15}$ of a grain every two hours to a child ten years of age. For topical application it may be made of the usual strength for dressing wounds. Among other uses to which corrosive sublimate has been applied during the year not the least is its application in the treatment of ringworm. Its efficacy is much enhanced by dissolving it in tincture of myrrh, in the strength of four grains to the ounce. The part is painted with the solution twice a day. In the treatment of infectious diseases, and especially typhoid, carbolic acid has been still further experimented with, the results being on the whole satisfactory. It is claimed by those who have tried it that the tongue remains moist, the diarrhœa is lessened, action of the skin is promoted, and the appetite early restored under its use. Dr. Wilks, of Guy's Hospital *(Med. Times and Gazette)* claims to have had very satisfactory results in the treatment of cases of diabetes mellitus with nux vomica and the mineral acids. The patient gained in weight, digestion was improved and the remedies seemed to have a specific action upon the glycogenic function. Dr. Peyer, of Nottingham, Eng., *(Lancet)*, utters a caution to medical men concerning the danger of using iodide of potassium internally and calomel externally, owing to the liability of the latter being formed into the iodide of mercury, and produce destructive action in the part. He gives his own experience in one case and refers to other published cases in support of his contention. The use of paraldehyde in the treatment of *delirium tremens* has again been brought forward by Prof. Gugl. He claims that it proves a prompt hypnotic, and in no case were there any unpleasant symptoms. The dose is from three to six or eight grammes. Dr. Galicer, of Versailles *(Bull de Therap.)*, recommends the use of strychnine hypodermically in cases of paralysis. He maintains that used in this way it stimulates the muscles, producing a local as well as a general effect; in other words, it acts like electricity in paralysis. Notwithstanding the great successs in the use of bichloride of methylene as an anæsthetic agent in the hands of Spencer Wells, it has not received much attention from the profession generally. This has no doubt arisen from the fact that two or three deaths occurred from its use when first introduced. M. Le Fort, of Paris, has been giving attention to this agent during the past year, and has come to the conclusion that it is superior to chloroform, inasmuch as the stage of excitement is much less marked and there is scarcely ever any vomiting. This is what Spencer Wells, who has used it in hundreds of laparotomies, always claimed for it. The external use of iodoform-collodion in the treatment of erysipelas has been highly extolled by Dr. Burman *(Practitioner)*. He claims that it promptly relieves the burning sensation, reduces the swelling, and arrests the progress of the disease. In acute rheumatism the use of ten minim doses of oil of gaultheria is highly recommended by those who have given it a fair trial. This is not to be wondered at when it is remembered that this substance was the original source of that excellent remedy salicylic acid. In the treatment of angina pectoris with sodium nitrite further successful cases have been published during the year. It should be given in three to five grain doses, as larger quantities are likely to produce unpleasant symptoms. The value of bromide of sodium in the treatment of epilepsy has been made the subject of investigation by Prof. Germain Sée, the result of which is to increase general confidence in its use. He says the efficacy of the drug rests almost exclusively on the depressing influence it exercises on the reflex action of the spinal cord and medulla, and he would therefore rigidly proscribe all stimulants of every form—such as alcohol, tea, coffee, etc. Further use of nitro-glycerine iu this affection also shows its value in certain cases in arresting the frequency and violence of the fits. The dose is from one to two drops of a one per cent. solution three or four times a day. As a means of distinguishing between simple ectasis or dilatation of the stomach, and that due to stricture of the pylorus from carcinoma, the fact first pointed out by VanderVelden, and recently investigated by Dr. Kredel, of Giessen, viz., that free hydrochloric acid is absent in the ejecta in cases of carcinoma, is, if true, a most significant and valuable

aid in diagnosis. The results of Dr. Kredel's researches are not only most assuring, but they also afford a hint for the medicinal treatment of these unfortunate cases.

In the domain of general and operative surgery there are many interesting facts to record during the year. A valuable point in intestinal surgery has been given to the profession by Dr. Rand in the LANCET, viz., a means of identifying the upper and lower ends of any given piece of small intestine. The mesentery is the guide. Holding the bowel in its true direction, and passing the hand on the right side back to the spinal attachment of the mesentery, it will be on the right side of the spine; but should the apparent upper end be in reality the lower, or, in other words, be held in the wrong direction, the hand passed to the right of it will pass to the left of the spine, and *vice versa*. Mr. Lawson Tait, in the (*Brit. Med. Journal*), gives his method for the radical cure of umbilical hernia by abdominal section, and considers it applicable to other forms of hernia. He opens the sac, frees all adhesions, cuts off omentum that may be in the way, pares the edges of the ring, and stitches up the wound with a continuous silk thread which he leaves permanently. The results have been most satisfactory. The subject of rectal etherization was brought prominently before the profession during the early part of the year, but though taken up with alacrity at first, seems already to have been almost entirely lost sight of. This is to be regretted, as there are no doubt cases in which this method of producing anæsthesia is valuable—such as operations upon the mouth, throat, and palate. We gave in our columns at the time full instructions as to its mode of administration. An improvement upon the ordinary operation for cancer of the rectum has been proposed by Mr. Pollosson. It consists in first making an artificial anus at the sigmoid flexure, and subsequently removing the cancer of the rectum. His idea is, that by this method the rectum is rendered passive and inert before extirpation, and many dangers are thereby avoided. The removal of a cancer of the anus and rectum was successfully performed in the Toronto General Hospital by Prof. Fulton, of Trinity Medical College. The entire anus and three inches and a half of the rectum were removed. The subject of so-called "catheter fever," was brought under the notice of the profession by a paper read before the London Medical Society, by Sir Andrew Clarke. By catheter fever is meant a severe and sometimes fatal form of fever following the use of the catheter in apparently healthy persons, in whom no lesions to account for death can be found post mortem. As a preventive he advises the use of opiates or anæsthetics, in cases where trouble of this kind may be expected, or has previously occurred. The general opinion of surgeons on this subject, however, is that what Sir Andrew Clarke alluded to was not new, but only one of the forms of urinary fever which follows the use of the catheter. The surgical treatment of large bronchoceles, has been discussed from various points of view. Some recommend their removal by the knife, tying all large vessels entering the tumor before division, so as to prevent loss of blood. Others have successfully treated them by the seton. Another method consists in cutting down upon the isthmus and applying a ligature at its juncture with the lateral lobe on each side and removing the isthmus. In a case operated upon in this way, by Mr. Sidney Jones, great relief from dyspnœa followed. The application of an elastic ligature around the base of the growth has also been quite recently recommended. The treatment of senile gangrene was the subject of discussion before the Royal Chirurgical Society, London. Mr. Jonathan Hutchinson read a paper recommending amputation high up in all cases of senile gangrene, viz.: in the lower third of the thigh and the middle of the arm. In the discussion that followed Mr. Savory said that if the causes were chiefly local, amputation might be successful, but if constitutional it would not, and in such cases he would prefer to leave it to nature. A little later on a very important paper was read before the above named society by Mr. F. Treves, on the direct treatment of spinal caries by operation. In cases of commencing psoas abscess, he cuts down along the outer border of the erector spinæ, opposite the last dorsal and first lumbar vertebræ—the most common site of abscess, gives exit to the pus and removes any sequestra of bone which may be found. In one instance he evacuated 40 ounces of pus and removed a large sequestrum from the body of the first lumbar vertebra. The improvement in the patient's condition was immediate. Several interesting and important cases of suturing the intestines have been reported,

besides experiments on the lower animals, to determine the best method of treatment. The results of treatment in these cases have been such as to lead us to adopt active surgical interference in all cases of traumatic lesion of the bowels. A modification of the Lembert interrupted suture is the one most strongly recommended. The late Prof. Gross, in a paper republished in our columns, very properly, we think, recommends the interrupted silk ligature in preference to catgut. Dr. McDonald, of Edinburgh, reports a case in the March number of this journal, in which he removed several inches of the small intestine, in the course of an abdominal section for extra-uterine pregnancy. The patient made a good recovery. A very interesting case of gastrostomy is reported by Prof. Loreta *(Lancet)*, for stenosis of the cardiac orifice. After making an opening into the stomach, the cardiac orifice was dilated by means of a suitable instrument, and the patient made an excellent recovery. Resection of the lung in acute pulmonary gangrene has been successfully performed by Dr. Fenger, of Chicago. In this case an incision was made parallel to the clavicle, the ribs exsected sufficiently to permit of the operation, and an opening made through the lung tissue into the cavity with the thermo-cautery. Portions of the putrefied lung tissue were discharged through the opening, and the patient made a good recovery. In the matter of osteotomy for genu-valgum, Dr. McEwen's supra-condyloid operation has come to be regarded as the most successful in its results, and at the International Medical Congress this fact was publicly acknowledged.

Nerve suturing has been again still further put to the test. A case is reported in the *Brit. Med. Journal*, Nov. 29th, in which Prof. Von Bergmann removed two inches of the shaft of the humerus in order to be able to unite the nerves which had been widely separated as the result of a wound by a circular saw. Successful cases of extirpation of the spleen have been chronicled from time to time during the year. A successful case was recently reported by Von Hecker, assistant to Billroth. So far there have been 36 cases of extirpation of the spleen. Of these 24 were for leukæmia, of which only one recovered.

The antiseptic treatment of wounds, *a la* Lister, is still being carried out by his disciples in all parts of the world, but the antiseptic agents used are being changed from time to time. Corrosive sublimate dissolved in blood-serum (1 part to 100) is the agent recommended by Mr. Lister at a recent meeting of the London Medical Society. The introduction of the new local anæsthetic muriate of cocaine in ophthalmic and general surgery will within certain limits undoubtedly prove of great value to the profession. It is easily applied and its anæsthetic effects are sufficiently complete to render it useful in operations where a transient effect is all that is necessary.

In the matter of obstetrics and gynæcology there has been much material progress. In the early part of the year the subject of puerperal fever occupied the attention of some of the most prominent gynæcologists, and much was said and written regarding the use of prophylactics, the practical outcome of which was to impress upon the professional mind the oft-repeated maxim that cleanliness is the greatest of all prophylactics. As is usual in human affairs there was a tendency manifested to go to extremes in regard to the measures to be used to prevent the occurrence of puerperal fever, septicæmia, etc. Dr. Thomas, who read a paper before the N. Y. Academy of Medicine, strongly advocating the most active interference in the puerperal state, afterwards so far modified his former expressions of opinion as to bring them into harmony with those who advocated less active measures. The combined method of turning in placenta prævia has again been brought more fully under the notice of the profession by Dr. Behm, of Berlin. The advantages claimed for this method are the avoidance of sepsis and the limitation of the loss of blood, from atonic post-partum hemorrhage. His plan is to leave the case entirely to nature after getting the breech down to the os—"haste" in performing combined turning, "delay" in extraction. The application of the forceps to the breech in certain cases has also been advocated by Truzzi *(Gas. Med. Ital.)* contrary to the teaching of former times. He regards their use as preferable to traction on the groin by the finger, fillet or blunt hook. Porro's operation has been the subject of earnest discussion, by some of the leading gynæcologists during the year. Dr. Godson read a very interesting and valuable paper on this subject before the British Medical Association in Belfast, giving ample data upon the status of the operation from a statistical point of view. In 131

cases the total mortality amounted to a fraction over 55 per cent. from which he is warranted in drawing the inference that the operation is one from which most satisfactory results may be obtained in properly selected and managed cases. Too many such cases are put off until it is too late to expect a successful issue. In the vomiting of pregnancy, iridin has been recently most enthusiastically praised as a remedy. M. De Musy *(Progrès Medical)* stated at the Société de Therap. that the Edinburgh physicians has used it extensively. Dr. Berry Hart had used it in ten cases without a single failure. The dose is three grains in pill form with conserve of roses every night, followed by a saline purgative in the morning. Hydrastis Canadensis has been used with great success by numerous observers both at home and abroad, in the treatment of uterine hemorrhage, and the results have been on the whole most satisfactory. It appears to produce contraction of the arterioles and lessen congestion, its action being somewhat similar, but more reliable than ergot. The dose is ten to twenty minims of the fluid extract. In the treatment of uterine displacements, Dr. Bell *(Lancet)* claims to have had excellent results from the use of medicated tampons. The substances he uses are alum, carbolic acid and glycerine, which he says support, deplete and invigorate the uterus and vagina. Mr. Lawson Tait reports *(Brit. Med. Jour.)* five cases of laparotomy for extra-uterine pregnancy, with four recoveries. The diagnosis in these cases is perhaps the most difficult part, but Mr. Tait never hesitates to open the abdomen. If a patient has been eight weeks or more without a period, and a pelvic mass can be felt on one side of the uterus and fixing it, and if sudden symptoms of pelvic trouble and hemorrhage come on, rupture may be suspected and abdominal section should be performed at once. Mr. Tait in his address on abdominal surgery at the meeting of the Canada Medical Association, gave us some idea of the reason of his remarkable success, viz., entire restriction to his chosen field, minute attention to every detail, together with great attention to cleanliness in every part of his work.

The association meetings during the year were more than usually well attended, and an increasing interest was manifested in all the proceedings. The various Provincial Associations in Ontario, New Brunswick and Nova Scotia, were well attended, and much valuable work was accomplished. The New Brunswick Medical Association decided to enter upon the experiment of publishing a quarterly medical journal, but we have not yet seen the first number. The Canada Medical Association met in Montreal in August under the presidency of Dr. Sullivan of Kingston, and under the most favorable circumstances. The interest of the meeting was greatly enhanced by the presence and active co-operation of members of the British Association for the advancement of science. Many instructive and valuable papers were read and discussed, not the least of which was the admirable address on abdominal surgery by Mr. Lawson Tait. The profession of Montreal in their hospitality exceeded all previous efforts, and both the social and intellectual proceedings were highly spoken of by all who participated. Dr. Osler was elected President for the ensuing year, and Winnipeg was chosen as the next place of meeting on the third Tuesday in August, '85. The American Medical Association met in Washington in May, under the presidency of Dr. Flint, Sr. Upwards of 1200 members were present and the meeting was most successful in every respect. The code, contrary to what was expected in some quarters, occasioned no difficulty. The work of the session was well sustained. The Journal of the Association came in for a share of criticism, but it was decided to give it another year's trial. Dr. Campbell, of Georgia, was elected president, and New Orleans chosen as the next place of meeting on the last Tuesday of April, 1885. The meeting of the British Medical Association was held in Belfast in July, Dr. Cuming, president, in the chair. A number of distinguished foreigners were present, besides delegates from the United States and Canada. Able addresses were delivered on medicine, surgery and obstetrics, and the work of the sessions was earnest and active. The social aspect was of the most brilliant and hospitable character. The eighth session of the International Medical Congress opened in Copenhagen on the 10th of August, under most favorable auspices. The attendance comprised about 1600 medical men of all nationalities. The meeting both intellectually and socially was a great success. The next meeting is to take place in Washington, in 1887, under the presidency of Dr. Flint, Sr.

During the past year the following new books and new editions of old ones have been issued from the press:—Syphilis in New-born Children and Infants, Diday; Materia Medica and Therapeutics, Bartholow; Student's Manual of Chemistry, Witthaus; Operations of Surgery, Bell; Pathology and Treatment of Venereal Diseases, Bumstead; Roller Bandage, Hopkins; Medical and Surgical Uses of Electricity, Beard; Manual of Diseases of Nose and Throat, Kitchen; Oral Surgery, Garretson; Hand-book of Chemistry, Greville; Hand book of Skin Diseases, Kippax; Influence of the mind upon the body, Tuke; History of Tuberculosis, Spina; Manual of Practical Hygiene, Chaumont; Bright's Disease of Kidneys, Millard; Practical Pathology, Woodhead; International Encyclopædia of Medicine, vol. iv., Ashhurst; Dictionary of Medicine, Quain; Treatise on Pharmacy, Parrish; Therapeutic Hand-book of U. S. Pharmacopœia, Edes; Manual of Obstetrics, King; Treatise on Surgical Diagnosis, Ranney; Epitome of Skin Disease, Fox; Guide to American Students in Europe, Hun; Hand-book of Forensic Medicine and Medical Police, Husband; "Shakespeare as a Physician," Chesney; Elements of Pharmacy, Materia Medica, and Therapeutics, Whitla; Opera Minora, Seguin; Elementary Principles of Electro-Therapeutics, Haynes; Medical Ethics Hamilton; Elements of Surgical Pathology, Pepper; Clinical Lectures on Mental Diseases, Clouston; Brain Exhaustion, Cornell; Deutch's Medical German; Diseases of Rectum and Anus, Kelsey; Gonorrhœa, Milton; Obstetrics, Verrier; Diseases of Heart, Paul; Eczema, Buckley; Second Annual Report of Ontario Board of Health; Clinical Chemistry, Ralfe; Dissector's Manual, Clarke; American System of Practical Medicine, Pepper; Electro-Therapeutics, Amidon; Diseases of Throat and Nose, McKenzie; Diseases in Children, Smith; Manual of Obstetrics, Partridge; Auscultation, Percussion and Urinalysis, Leonard; Visions of Fancy, Baskett; Hooper's Physician's Vade Mecum; Materia Medica and Therapeutics, Bruce; Principles and Practice of Medicine, Davis; Practical Medicine, Loomis; Malaria and Malarial Diseases, Steinberg; Diseases of Women and Uterine Therapeutics, Jones; Medical Rhymes, Erichsen; Lock-jaw of Infants, Hartigan; Fractures and Dislocations, Hamilton; Science and Art of Surgery, vol. i., Erichsen; Pathology and Morbid Anatomy, Greene, etc.

Among those of our confrères who have passed away during the year, may be mentioned,—S. F. Whitman, Bridgetown, N. S.; H. Bennett, Priceville; J. Reddy, Montreal; J. Thomson, Chatham, N. B.; J. R. Tabor, Whitevale; A. C. Savage, Chicago; J R. Smith, Harrowsmith; C. H. Lavell, Kingston; R. Black, Wickham, N. B.; E. Clay, Halifax, N. S.; J. F. Coad, East Zorra; C. Deguise, Quebec; Wm. James, Burgessville; P. N. Leclair, North Lancaster; S. W. Cooke, Paris; —. Kittson, St. Paul, Minn.; J. J. Dickinson, Cornwall; R Stephen, Digby, N.S.; J. E. Landry, Quebec; H Maudesley, Moorefield; H. C. Fixott, Arichat, N. S.; E. Morton, Queensville; G. A. Kent, Wallace, N. S.; J. A. Aikman, Ingersoll; J. S. Diamond, Toronto; G. Willcock, Toronto; E. Jennings, Halifax; G. H. Nelson, Santa Barbara, Cal.; Jas. McCammon, Kingston; A. B. Craig, Montreal, etc. Among those in foreign lands may be mentioned,—Prof. Balfour, Alex. Wood and Allan Thomson, Edinburgh; C. H. Hawkins, London, Eng.; Prof. Jäger, Vienna; —. Radcliffe, Engiand; Prof. Cohnheim, Leipsic; Profs. Gross and Rogers, Philadelphia; Prof. Parker, New York; Dr. Dugas, Georgia; Dr. L. P. Yandell, Louisville, etc.

The outbreak of cholera during the past year in the south of France and its extension to other points in Europe, and recently to Paris, strikes the note of alarm, and bids us prepare to ward off the impending blow. Our sanitarians in Canada and the United States are united in making representations to their respective governments, with the view of dealing promptly with the adversary should it unfortunately reach our shores. Various outbreaks of smallpox and diphtheria have taken place at different times and in different localities, but upon the whole the health of the community has been no worse than in former years. We conclude by wishing our many readers a happy new year, great and increasing prosperity, and long lives of usefulness.

JAMES McCAMMON, M.D., M.R.C.S., ENG.

Dr. McCammon, whose death recently took place, was born in Kingston, Ont., in 1833, and there received his primary education. On reaching manhood he first devoted his attention to school teaching, after qualifying himself for the duty by

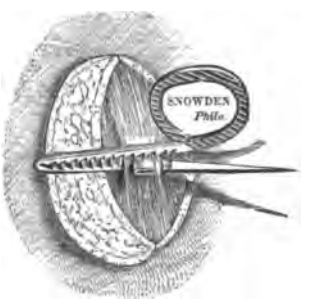
attendance at the Normal School, Toronto. He followed this occupation with remarkable success for several years, after which he turned his attention to the study of medicine, and graduated with honors in Queen's College in 1863. He subsequently practised for several years in Newburgh, Ont., where he acquired a lucrative practice. In 1871 he visited the European hospitals determined to acquire experience and obtain a wider knowledge of surgery and physic. He there obtained the diploma of the Royal College of Surgeons, Eng., and on his return settled in Kingston. He was for several years a member of the Ontario Medical Council, and was recently appointed to the chair of clinical surgery in the Kingston Medical School, which position he filled with marked ability and favor. He was also a member of the Council of Queen's University, He was elected mayor of his native city in January last, and was most assiduous, as indeed in everything else, in the performance of his civic duties. In the death of Dr. McCammon the profession of Canada has lost one of its most active and intelligent members and the city of Kingston its chief magistrate and one of its most valuable citizens. The sick poor of the city have lost a sincere and self-sacrificing friend, and his wife and family a devoted father and husband.

THE LYNAM CASE.—About two years ago Mrs. Lynam was considered insane, and was sent to the Longue Point Asylum by the certificate of the visiting physician. Recently a Mr. Perry, who interested himself in her behalf, became convinced that she was sane, and applied to Judge Jette to have her produced in court, in order to test the question of her sanity or insanity. Experts, or so-called experts were called to testify, and as is usual under such circumstances, some of them declared her insane, while as many of equal authority pronounced her sane. The judge was, of course, bewildered, and accordingly put Mrs. Lynam in the witness box, and is said to have given her a most severe examination, which she bore with great calmness and fortitude. He finally decided to appoint Dr. Vallee of the Beauport Asylum, to examine her, and suggested that the Quebec Government should appoint two others to act in conjunction with him. The government have been dilatory in the matter, but Dr. Vallee has visited Mrs. Lynam, and has filed his report in the superior court, declaring her in his opinion, to be sane.

ARTERY-COMPRESSOR.—A convenient and effective appliance has been devised by Dr. Levis for the rapid arrest of hemorrhage in large open wounds. It is exceeding simple and inexpensive.

Numbers of the compressors can be quickly applied during an operation, and the surgeon may leisurely ligate the vessels if after their removal, the ligature should be required. In many operations attended for the time by great hemorrhage from numerous small vessels, the temporary stasis produced by the compressors will be sufficient to prevent further flow.

By this device the operator can proceed to the end of an operation without stopping to apply ligatures.



The instrument and its application are so illustrated in the cuts that description is unnecessary. The compressors are made by Snowden, 7 South Eleventh Street, Philadelphia, and the price is only 25 cents each.

SUBCUTANEOUS INJECTION OF MORPHIA IN CHOLERA.—Dr. Brown, of Clayton, Ont., has called our attention to the following which was published in the LANCET several years ago, and which we now re-publish : " Dr. Patterson, of Constantinople (*Braithwaite*), reports that in the late epidemic of cholera in that city, finding all other treatment unsatisfactory, he determined to try the subcutaneous injection of morphia. In the first case a quarter of a grain of the acetate caused relief to the cramps and vomiting in a quarter of

an hour, and the skin became gradually warm and moist, and the pulse returned. In ordinary cases he found one or two injections sufficed, in a few three were given, and only once four. He does not maintain that the treatment is a specific against cholera, but that its action is more speedy, certain and effectual than any other tried by him. Out of thirty-two cases in which the treatment had a fair chance, there were only ten deaths."

MORE ADVERTISING IN THE LOCAL PRESS.—Inasmuch as the LANCET is again on the war-path, the following "most extraordinary case" under the care of Dr. Hamilton, of Port Hope, Ont., may be alluded to. The item, which appears to have been written, or at all events the facts supplied by a medical man, appeared in the *Port Hope Guide*, Dec. 5th. A young man was wounded in the orbit by a piece of wood. The doctor, after "probing the wound, discovered a foreign body," and advised an operation. He gave chloroform, "enlarged the wound," and on laying hold of the "foreign body" with a "strong forceps," removed it, &c. We leave our readers to judge of the paternity of the offspring.

INTERNATIONAL MEDICAL CONGRESS. — The Committee on Organization of the 7th International Medical Congress, to be held in Washington in 1887, met recently and the following officers were elected: *President*, Dr. Austin Flint, Sr., New York. *Vice-Presidents*, Dr. Alfred Stille, Philadelphia; Dr. Henry I. Bowditch, Boston; Dr. R. P. Howard, Montreal. *Secretary-General*, Dr. J. S. Billings, U. S. Army; *Treasurer*, Dr. J. M. Browne, U. S. Navy. *Members of the Executive Committee*, Dr. I. Minis Hays, Philadelphia; Dr. Jacobi, New York; Dr. Johnston, Baltimore; Dr. Busey, Washington.

REMOVAL OF LARGE CALCULI.—Dr. Hingston, of Montreal, removed from the bladder a calculus weighing five ounces and five drachms, and measuring upwards of nine inches in its greatest circumference. The lateral method was adopted and the patient, a youth of 21 years, made a rapid recovery. Dr. Burns, of the Toronto General Hospital, also removed a calculus from the bladder a few months ago by the supra-pubic method, weighing three and a half ounces, and measuring two and three quarter inches in its greatest diameter. The patient, aged 21 years, unfortunately died within 24 hours.

REMOVAL OF A TUMOR OF THE BRAIN.—Mr. Godlee recently removed a tumor from the substance of the brain at the hospital for epilepsy and paralysis, London, Eng. The case was under the care of Dr. Hughes Bennett, who diagnosed the existence of a tumor in the upper part of the fissure of Rolando, and requested the surgeon to trephine over the suspected region. A mass of glioma the size of a walnut was successfully removed and the patient had progressed favorably up to the time of writing.

SANITARY CONGRESS.—Dr. C. W. Covernton, Chairman of the Ontario Board of Health, has been requested by the Dominion Government to represent Canada at the Sanitary Congress held in Washington. Dr. Canniff, medical health officer for Toronto, has also been sent as a delegate. The object of the meeting is to recommend to the governments of the United States and Canada the adoption of measures to prevent the invasion and spread of cholera, which is confidently expected to visit our shores next summer.

REMOVAL OF A CYSTIC KIDNEY.—Dr. McLean, Prof. of Surgery, Ann Arbor, Mich., (*Phys. & Surg.*) formerly of Kingston, Ont., removed the left kidney which was in a state of cystic degeneration, both ovaries and a portion of the greater omentum, on the 26th of October last, from a woman supposed to be pregnant (2nd or 3rd month). At last accounts, seventeen days after the operation, the patient was doing well.

EPIDEMIC OF SMALL-POX.—An epidemic of this loathsome disease has broken out in the county of Hastings. In the village of Stoco, scarcely a family has escaped the scourge. The secretary of the Ontario Board of Health, Dr. Bryce, has made a tour of inspection of the district, and is doing all in his power to prevent the spread of the disease.

VACANCIES IN U. S. ARMY AND NAVY. — The *Medical Record* of New York states that for several years there have been a number of vacancies in the United States army and navy medical department. There are not enough applicants to fill the situations. This ought not to be the case, inas-

much as the position is a very desirable one for a young man, and the salary is very good.

ANOTHER LOCAL ANÆSTHETIC.—Our attention has been drawn by Dr. Ryerson of this city to the anæsthetic powers of Rhigolene, a drug introduced to the profession some time since by Dr. H. J. Begelow, of Boston. Rhigolene is a naphtha obtained by re-distillation of petroleum. It is not a definite compound but is the most volatile liquid known and one which produces the greatest cold on evaporation. It is highly inflammable. Used in the form of a spray it freezes rapidly and *deeply*. Its effects are somewhat evanescent, but can be maintained by frequent sprayings. It seems likely that Rhigolene may play a prominent rôle in general surgery, inasmuch as the hydrochlorate of cocaine has been found to be a comparative failure when applied to the un broken skin, and whn injected hypodermically has produced unpleasant constitutional symptoms, with imperfect local results.

LIGATURE OF THE CAROTID AND JUGULAR VEIN.—Dr. Deakin (*Lancet*, Nov. 15th), has recently applied a ligature to the right common carotid artery, and two to the jugular vein, in the removal of an epithelial tumor of the neck. Although a cure could not be looked for in the case, the result of the operation was satisfactory.

AMYL NITRITE IN ASTHMA.—Dr. W. B. Richardson, of London (*Asclepiad*, July, 1884) gives the following formula for its administration: ℞. Amyl Nitrite, M. xxxv., Alcohol, ʒv., pure glycerine to ʒiss,—M. One fluid drachm in a wineglassful of warm water.

SUCCESSFUL OVARIOTOMY—Mr Knowsley Thornton has lost but three of his last one hundred ovariotomies. He is a follower of Lister. Of the three patients that died one had malignant disease and the others died of hemorrhage.

THE death of Dr. Henry Martin, of Boston, who has been for years identified with vaccination, is announced in our exchanges. His son will continue the business.

GLEET.—Pinus canadensis is a specific in gleet. Its action is prompt and permanent.

Books and Pamphlets.

A PRACTICAL TREATISE ON FRACTURES AND DISLOCATIONS, by Frank Hastings Hamilton, M.D., LL.D., late Prof. of Surgery in Bellevue Medical College and Surgeon to Bellevue Hospital, New York; St. Elizabeth Hospital, etc.; Author of a Treatise on Military Surgery and Hygiene, a Treatise on the Principles and Practice of Surgery, etc. 7th American edition, revised and improved. Illustrated with three hundred and seventy-nine wood cuts. Philadelphia: H. C. Lea's Son & Co. Toronto: Williamson & Co.

This most excellent and classic work of Prof. Hamilton has now been before the profession for a quarter of a century, and is well known to surgeons both at home and abroad. The present edition has been carefully revised and re-written, and new matter has been introduced, which adds to its value as a work of reference. The work now comprises about 1,000 pages octavo, and is noted alike for its originality and completeness. The author has taken nothing for granted, and commends no procedure for which he does not find a warrant in the results of his own experience. From the beginning of his studies, he declares, he has found one of his most difficult labors in attempting to eliminate from surgery the numerous "false facts" or unreliable statements derived from observations made on the cadaver or on cabinet specimens whose history is unknown. We unhesitatingly recommend the work to our readers.

THE SCIENCE AND ART OF SURGERY.—By John Eric Erichsen, F.R.S., LL.D., F.R.C.S.; Emeritus Prof. of Surgery in University College, etc. Eighth Edition. Revised and Edited by Marcus Beck, M.D., Land, F.R.C.S., Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Volume I. Large 8vo. Pp. 1124. Philadelphia: Henry C. Lea's Sons & Co. Price, $5.50.

Each of the various editions of this magnificent work has been noticed by us from time to time. It is only necessary for us now to inform our readers in regard to the present edition, which the author has thoroughly revised in order to bring it abreast of the knowledge of modern surgery. Erichsen's surgery since its first publication, more than thirty years ago, has held a position second to no other work upon surgery as a text book or a work for reference both in England and in this

country. When it consisted of but one volume, its convenient size and completeness of detail commended it, in our estimation, as one of the most valuable texts books for students. Yet although enlarged and made into two volumes, it is so free from prolixity and tediousness that we have no hesitation in recommending it to the attention of students as well as the general practitioner.

THE NATIONAL DISPENSATORY, containing the Natural History, Chemistry, Pharmacy; Action and Uses of Medicines. By Alfred Still6, M.D., LL.D., and John M. Maisch, Phar. D. Third Edition thoroughly revised, with numerous additions, with three hundred and eleven illustrations. Philadelphia: Henry C. Lea's Son & Co., Toronto: Williamson & Co.

This valuable work is already so well known to the profession in Canada and the United States as to require only a brief notice at our hands. Complete information will be found in regard to all remedies, both old and new. Even in the matter of the new local anæsthetic it contains the fullest information. The work is almost a necessity to every practitioner of medicine as a book of reference.

DISEASES OF THE EYE, by Henry R. Swanzy. New York: D. Appleton & Co. Toronto: Hart & Co.

This book, which is about the same size as Dixon on the eye, is intended for the use of students attending an opthalmic hospital, but will also be found very useful as a convenient work of reference for practitioners. The work is largely a compilation from standard works. The author rarely putting forward his own opinion or practice very prominently. The work is well and appropriately illustrated, and the text well written. A very interesting chapter treats of the motions of the pupil in health and disease.

MANUAL OF CHEMISTRY by W. Simon. Philadelphia: Henry C. Lea's Son & Co. Toronto: Hart & Co.

This may be considered, in some respects at least, as a companion work to the foregoing. It is intended as a guide to a course of lectures on general chemistry, but will be found especially useful to pharmaceutical and medical students. The work treats of organic and inorganic chemistry, qualitative analysis, physiological chemistry, etc. The work is well printed on good paper and clear legible type, and is well adapted to the use of the general student of chemistry.

PHYSIOLOGICAL AND PATHOLOGICAL CHEMISTRY, by T. Cranstoun Charles. Philadelphia: Henry C. Lea's Son & Co. Toronto: Willing & Co.

A knowledge of this branch of medicine is of great importance in the study of the science and art of medicine. Physiological chemistry promises much in the treatment of disease. The work before us gives an excellent outline of the most important branches of physiological chemistry, and in order to render the work more complete the author has given brief descriptions of such bodies as sugars, fats and certain salts. We commend the work to the attention of the student of chemistry.

THE PHYSICIAN'S VISITING LIST (Lindsay & Blakiston) FOR 1885. Thirty-fourth year of its publication. Philadelphia: P. Blakiston, Son & Co.

This popular List continues to maintain its former reputation. It was the pioneer in this line of publications, and fulfils every requirement of a daily companion. Every practising physician should have a visiting list; it will save him ten times its cost in the year.

THE MEDICAL RECORD VISITING LIST FOR 1885. New York: W. Wood & Co.

We have received a sample copy of this valuable and popular visiting list. In its preparation nothing has been omitted which is necessary in a pocket record. It is most concise, compact, and handsomely finished work, and will be found a most useful companion.

Births, Marriages and Deaths.

On the 10th of December, P. J. Strathy, M.D., M.R.C.S., Eng., to Fannie, youngest daughter of the late J. Alley, Esq., Toronto.

In Kingston, on the 29th of November, James McCammon, M.D., Mayor of Kingston, aged 51 years.

In Montreal, on the 12th of November, A. B. Craig, M.D., aged 60 years.

*** *The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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Original Communications.

INTERNAL OBSTRUCTION OF THE BOWELS.

BY A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N.B.)

CASE I.—August 12th, 1883. G. L., male, æt. 25. Always healthy. Never laid up by illness in his life. Ate some green peas at yesterday noon, and a quantity of ham in the evening. Was seized with violent pain in the abdomen at 1 a.m. A free movement of the bowels took place at 3 a.m. Pain continued and vomiting then also began. 30 drops of laudanum were administered by a friend, but with little relief. Was visited by me at 8 a.m., when I gave ⅓ gr. of morphine hypodermically. This kept the patient pretty easy till noon, when half an ounce of castor oil with 30 drops of laudanum were taken. At 5 p.m. the pain became so severe again that I repeated the morphine as before.

Aug. 13, 8.30 a.m.—Pain returned early this morning. Vomiting is frequent and copious, and no motion of the bowels has occurred since yesterday morning; morphine repeated, also half a drachm of spirits of turpentine in warm soap and water administered in the form of an enema; to be followed in half an hour, if no action of the bowels, by a quart of warm water. Turpentine stupes externally.

8 p.m.—Free vomiting during the day, though only 2 or 3 cups of tea have been swallowed. Vomited matters are of a sour taste and smell, and also very bitter. No flatus has passed per anum since the attack began; neither has any of the enemata come away. Pulse, 104; temp. in mouth, 99.8°. Little or no abdominal distension. Pain and tenderness are greatest in the epigastric region. Morphine repeated in the arm. Also ordered a pill of ⅓ gr. morphine and ½ gr. of ext. belladonna, to be given pro re nata. To have only iced milk and lime water in small quantities.

Aug. 14, 10 a.m.—Rested pretty fairly till 3 a.m., when the pain and vomiting returned. Has taken 6 of the pills since that hour, but probably several of them were vomited. The amount of greenish sour fluid ejected is still large, though little ingesta is taken. The urine has been very scanty from the first. Pulse, 96; temp. 99.2°. Face looks somewhat pinched. Hypodermic injection of morphine repeated. To suck bits of ice and swallow little else.

12.30 p.m.—Comfortable since morning, and not much vomiting. About 3 quarts of warm water administered very slowly as an enema through a long tube. No great amount of force was required to inject it, but the patient complained of a good deal of pain at the last, and I then desisted. He then got up and passed about two quarts in gushes. Little or nothing came away in the water. Ordered a suppository containing ¾ gr. of morphine and 1 gr. of ext. of belladonna pro re nata to relieve pain.

8.30 p.m.—Vomiting continues. Used one suppository about half an hour ago. No further motion from the bowels. Abdomen seems to be growing flatter, especially from umbilicus downwards. Pulse, 108; temp. 99.5°.

Aug. 15, 9 a.m.—Rested fairly well without any more opiate. Vomiting not quite so frequent, but the fluid thrown up has an intestinal odor. Had some hiccough during the night. Feels less pain; no improvement in facial expression. Pulse 96, small and compressible; temp. in mouth, 97.5°; in rectum, 99°.

11 a.m.—Dr. Coburn, of Fredericton, saw the patient with me, and agreed in the opinion that there must be some intestinal obstruction. As, however, he had been rather freer from pain and vomiting, and some flatus had passed per anum, for the first time this morning, it was deemed advisable to wait a few hours before operating. Pulse, 120; temp. in mouth, 99.8°; in rectum, 101°. Extremities rather cool.

8 p.m.—Vomiting of intestinal—smelling matter continues. Pulse 128, feeble; temp. as before. Mind has wandered at times during the day.

Operation (by lamplight).—Chloroform, followed by ether. Assisted by Dr. Coburn, and Messrs.

Owens and Sury, my medical students. The anæsthetics were taken badly. The catheter was passed but no urine found. A longitudinal incision was made, commencing to the left of the umbilicus and extending down about four inches. On cutting through the peritoneum, congested small intestine presented itself. On examination two loops were found connected closely together by a very short band of adhesion, which dragged upon one part so as to constrict very considerably the gut. I could scarcely insert the tip of the finger beneath this band and adjoining loops of bowel. A catgut ligature was thrown around the adhesion and tied. There was no room for a second one, and I therefore divided the band with the scissors. No bleeding followed. As only a few inches of the intestine seen was much distended, there was no protrusion; and I readily brought the abdominal wound together with deep silver sutures and superficial catgut ones. Carbolic spray and other antiseptic precautions were used throughout.

10.30 p.m.—The patient has been very restless and pugnacious since coming out of the ether, and it was with difficulty he could be kept in bed. Has swallowed a few teaspoonfuls of iced milk, and has had an ounce of brandy in a cup of warm milk and water by enema. No vomiting since the operation, and flatus has passed several times per anum. Extremities are pretty cold. Pulse 132, very feeble. Hot irons put to feet. ¼ gr. morphine subcutaneously, to help keep the patient quiet.

Aug. 16, 8.30 a.m.—Slept 4 or 5 hours altogether during the night. Took some brandy and milk by the mouth, and had an enema of the same at 3 a.m. No vomiting; no motion of the bowels. Wildly delirous at times. Extremities cold. Little or no pulsation at wrists. He died at 10.30 a.m.

Autopsy 11 a.m.—The point at which the ligature was applied was found to be only 4 feet from the pyloric end of the stomach. A considerable thickening of the peritoneal coat ran in a somewhat band-like form around the gut from the ligatured adhesion. Along this line the bowel presented somewhat of a wet leather appearance, but there was no ulceration of the mucous coat at the part, and the calibre of the intestine was not very greatly diminished either here or elsewhere. Stomach and upper 4 feet of bowel dilated; below this the latter was empty and contracted. Two of the mesenteric glands were calcareous.

CASE II.—Oct. 19, 1883.—A. J.'s child, æt. 11 months, female. A few weeks ago the child had measles, which was followed by a serious attack of bronchitis. Two or three days since the patient began to suffer from vomiting and diarrhœa, but was not ill enough for a physician to be sent for. At 2.30 a.m. the patient awoke with pain and vomiting, and the passage of a thin, bloody fluid from the bowels. Was visited by me at 5 a.m. I gave at once 6 or 7 drops of tinct. opii in a little warm water as an enema, and ordered her to have 2 drops of the same by the mouth pro re nata, also to take only one teaspoonful of barley water every half hour. The distress seemed very great when the patient vomited, and the fluid ejected resembled very much the rice water which she had been drinking during the night.

11 a.m.—Has required one or two doses of the laudanum, and has been much easier. No further vomiting, though there has been a little retching. Two bloody discharges. Continue opiate as before, and two teaspoonfuls of barley water at a time.

8 p.m.—Vomiting has come on again, and the bloody dejections have been more frequent. Pulse, 160; temp. beneath arm, 101°. Rather pale and collapsed-looking. On examination per rectum, no tumor felt, though anus seemed more patulous than usual. No great abdominal distension, and no marked tenderness on palpation. On deep pressure a cylindrical tumor was found lying just to the left of the median line, and extending from the pubes upwards to the side of the umbilicus, being about 3½ inches in length and 1¾ inches broad. Resonance not quite so good over the swelling, but no marked dulness present. I now wrapped a piece of rag about the base of the nozzle of a Davidson's syringe, so as to form a plug for the anus; and, holding the instrument tightly against the fundament, I injected slowly a pint or more of warm water, while at the same time I manipulated the tumor through the abdominal walls. During this procedure the swelling appeared to move somewhat towards the right and disappear. I now allowed the water to escape, and examined the abdomen again. No swelling felt above pubes, but as I imagined there was an abnormal fulness and hardness in the right hypo-

chondriac and epigastric regions, I repeated the enema with the head and shoulders lowered. During the administration of the last of the enema, about six ounces of greenish fluid burst from the mouth, and I then allowed the water to escape per anum. No fæcal matter, mucus, nor blood came away with either enema.

10 p.m.—Has rested well since enemata. No vomiting, and no movement of the bowels since visit. No tumor felt. Pulse, 145.

Oct. 20, 9 a.m.—Doing well; pulse, 136. Countenance improved. 9 p.m.—No vomiting since the disappearance of the tumor. Has had two or three greenish motions to-day. No blood.

Oct. 21.—Appears almost well. Takes the breast and vomits nothing.

REMARKS.—That a distended abdomen is not necessarily present in all cases of internal obstruction is quite evident from the first case reported above. The belly was really *retracted* in that instance, which was of course due to the seat of trouble being so close to the stomach, thereby leaving only a few feet of intestine above to be dilated, the portion below becoming empty and contracted as is usual. It would undoubtedly have afforded this patient a much better chance for life if laparotomy had been done earlier; but one is apt to hesitate and delay about resorting to so serious an operation, that the latter is often not undertaken until symptoms of collapse, or general peritonitis, or gangrene supervene, and then the patient succumbs. I intended to have performed the operation on the morning of January 15th. had there not occurred a passage of flatus downwards for the first time, which led me to hope that the obstruction was about to yield. Besides, it will be observed that the abdominal section was made before the end of the 4th day, and as I had previously operated on two cases* of internal strangulation at the end of the 5th and 6th day respectively—the former of which recovered, and the latter lived till the 7th day after the operation—I thought I could afford to wait a little. But it is quite clear that the *length of time* that has elapsed cannot be relied upon entirely as a guide to the condition of the bowel, and consequent urgency for surgical interference, any more in cases of internal obstruction than in those of strangulated hernia, and one must evidently be largely governed as to the advisability of immediate operation by the degree of the acuteness as well as the severity of the symptoms attending the attack.

As to the character of the second case reported, I think there can be little room for doubt. The acuteness of the symptoms, the vomiting, the passage of the thin, bloody serous discharges, the presence of the sausage-like tumor, and the speedy and complete relief obtained by the use of the large enemata, all combine to prove the existence of an intussusception. The patulous condition of the anus, I think, is also mentioned by some as likely to be found in such cases. I did not give an anæsthetic before administering the enemata, because I did not suppose there would be much muscular resistance offered to prevent the reduction of the bowel in a subject so young, and in one who was so much prostrated by the disease. The readiness with which that object was attained is sufficient evidence that the assistance of such was not required.

* Reported in Boston *Med. and Surg. Journal* of June, 1883.

THORACO-PLASTIC OPERATION OF ESTLANDER.*

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.
Prof. of Surgery and Clinical Surgery, in Trinity Medical College, Toronto; Surgery to the Toronto General Hospital; Author of Text-Book of Physiology.

GENTLEMEN,—It is not possible for me, within the time assigned, to discuss satisfactorily the pathology, or even the clinical history of empyema, although the disease is one of the most interesting which the surgeon is called upon to treat. I shall, therefore, confine myself entirely to the treatment of the chronic form of the disease by what is known as Estlander's operation. I also desire to draw the attention of the profession to this operation which, so far as I know, has rarely been performed in America the first reported case being given by Dr. Fenger, of Chicago, in the *Medical News* for Sept. 1882.

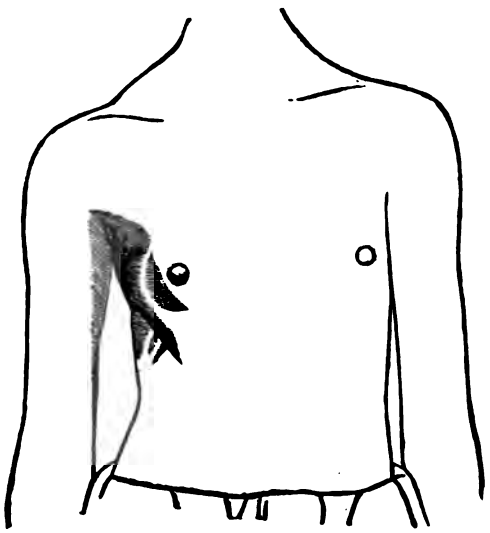
The resection of a portion of a rib for the more thorough evacuation of pus, and for the application of remedies to the cavity of the pleura, has long been practiced; but the object which Estlander had in view in his operation, was the obliteration of of the suppurating cavity and occlusion of the per-

*Read before the Canada Med. Association, August, 1884.

manent pleural fistulæ which are consecutive to the incision in empyema. I need scarcely say that nearly all intelligent surgeons of the present day treat cases of empyema, especially in the adult, by free incision and drainage, together with thorough washing out and disinfection of the cavity. The results of this method of treatment are, upon the whole, satisfactory. Dr. Homen, in an interesting paper in (*Archiv fur Klin, Chirurg*, Langenbeck's Journal), gives the statistics of 52 cases of empyema, treated by free incision, drainage and disinfection. Of these fifty per cent. recovered, thirty-three per cent. died, and in seventeen per cent. permanent fistulæ remained. This may be considered a fair statement of the average results obtained in general practice. The pleural fistula is in most cases, the result of the formation or existence of a cavity between the thorax and the lung, lined by soft pus-secreting tissue. This is much more likely to occur where the opening for the evacuation of pus has been made late in the disease, and where the expansive power of the lung has been impaired by the long continued pressure. The size of such a cavity, and the amount of pus discharged from the opening may vary very much, but even a moderate amount of discharge is not only a great inconvenience to the patient, but also a source of danger, by so depleting the system as to lay the foundation of amyloid degeneration of the kidney, spleen and liver, or tuberculosis. In view of these facts, it is clearly the duty of the surgeon to adopt every possible means in order to effect the closure of the cavity. In such cases Estlander's operation seems well calculated to secure the end desired. It consists in the removal of a portion of the chest wall, in order to produce a certain degree of sinking in, and allow the parietal and visceral layers of the pleura (or chest-walls and lung) to come into contact. Before proceeding to discuss the operation, its indications and contra-indications, and the after-treatment, I will report the following case occurring in my practice in the Toronto General Hospital :—

Mary B—æt 28 years, was admitted into the Hospital on the 6th of November, 1883. Parents living, family history good ; has had no illness since childhood, except the present, which took place on the 28th of April, 1882, from an attack of pleurisy. She was treated by Dr. Smith, of Walkerton, who discovered fluid in the pleural cavity of the right side on the 30th. He aspirated the chest twice during the months of May and June, removing large quantities of serous fluid. On the 8th of July, 1882, when the aspirator was again used, pus was discovered. The chest was then opened by incision and washed out daily from that time until July, 1883, when a second operation was performed in order to enlarge the opening in the chest which had nearly closed. In the latter part of August, 1883, she came under the care of Dr. Stalker, of Walkerton. He continued the treatment by washing out the cavity with a solution of salicylic acid, as carbolic acid had, on a previous occasion, produced symptoms of poisoning. From the time the first incision was made, July 1882, until the date of her admission into the Hospital, there was no appreciable change in her condition or the amount of the discharge. On admission the patient was spare and anæmic, but not extremely emaciated; appetite poor; slight hectic. The right side of the chest was sunken and flattened, causing a certain amount of lateral curvature of the spine and lowering of the right shoulder. In the axillary line, and between the sixth and seventh ribs was the opening in which a rubber tube was inserted. The amount of discharge was from two to four tablespoonfuls daily. In the upper part of the right side the percussion note was clear, but dull in the lower portion. Vesicular respiration was weak throughout, and almost indistinct in the lower part. The left lung was normal, pulse 90, temperature from 99 to 100: bowels regular, urine healthy. In the meantime the cavity was washed out daily with carbolic lotion 1 to 60, to which tincture of iodine was added. But as no improvement followed, on the 30th of November, in the presence of the members of the Hospital staff and medical students, I performed Estlander's operation. Ether was administered and the patient placed upon her left side. An incision about five inches in length was made between, and parallel to, the sixth and seventh ribs. The lower margin of the incision was drawn downwards by means of retractors, so as to expose the seventh rib. The periosteum was divided longitudinally in the median line of the rib, raised on each side, and a portion of the rib three inches long removed by means of a bone cutting forceps. The upper margin of the wound was then drawn upwards and a corresponding portion of the sixth rib removed in the same way. The pleura costalis which was much thickened, was not disturbed

except to make a larger opening by the introduction of the finger, for the insertion of a large-sized drainage tube. There was very slight hemorrhage during the operation, which was arrested by torsion no ligatures being required. The cavity was then thoroughly washed out with carbolic acid solution, a large drainage tube inserted, the wound sutured and dressed with marine tow. There was very little shock. At 6 p. m. pulse, 120; temperature, 99½; the patient felt comfortable with the exception of pain in the wound which was relieved by opiates. Without detaining you by recounting the daily history, I may say that her progress was quite satisfactory, with the exception of a rise in pulse and temperature on the third day which was readily controlled by five grain doses of quinine every four hours. The cavity was washed out daily with solution of carbolic acid, to which tincture of iodine was added; the discharge gradually diminished, and the patient's general health rapidly improved, so that she was able to leave the Hospital early in March, 1884. I have just received a letter from her former medical attendant, Dr. Stalker, in which he says, that she is greatly improved in her general health. He did not enquire as to her increase in weight since her return from Toronto, but it must



be considerable. The cavity is gradually becoming closed up, and he says he feels satisfied that in the course of a month the drainage tube now in use may be discarded, and the wound allowed to heal." Before she left the Hospital there was considerable sinking in of the chest, most marked opposite the sixth and seventh ribs, as shown in the diagram.

The ends of the resected ribs could be distinctly felt, but the tissue between had become more or less firm, showing an attempt at reformation of bone. The patient's general condition was much improved; her appetite was better, and her anæmia had almost entirely disappeared. The report above referred to shows that this improvement has continued, and that she is now almost entirely well.

With regard to the indications for the operation it may be stated in general terms, that in all chronic cases of empyema which have resisted ordinary treatment for a lengthened period, the operation should be resorted to. It is, of course, impossible to fix a stated period, that will apply to all cases; but when a fistula has existed from six to eight months without any sign of improvement, such as diminution in the size of the cavity, or the amount of the discharge, disappearance of hectic, or improvement in the patient's general condition, this procedure should be put in practice, provided there are no contra-indications, such as advanced tuberculosis, albuminuria, or extreme emaciation. The size of the cavity may be easily determined by passing a long probe or catheter through the fistula. Estlander has shown that "even in cases of extreme debility, patients being so weak as to be scarcely able to turn in bed, the operation caused very slight derangement of the system, and was followed immediately by marked improvement. It is scarcely necessary to say that if albuminuria be present from amyloid kidney, the patient is liable to succumb to very slight shock. The operation is by no means a trying one, and may be safely resorted to in very delicate subjects."

With reference to the operation itself, the position, size and direction of the incision will depend upon the situation of the cavity and the fistulous opening. The most favorable position is upon the lateral portion of the thorax in the axillary line, the intercostal spaces being there covered by the serrations of the serratus magnus. The length of the incision and portions of ribs to be removed will depend upon the size of the cavity in the horizontal direction. For the excision of portions of two or three ribs, one single incision parallel to, and either between the two or over the middle rib of the three to be removed, will be quite sufficient. If a greater number are to be excised, parallel

incisions may be made above or below as required. The number of ribs to be removed will be determined by the dimensions of the cavity in the vertical direction. The surgeon need not hesitate to remove portions of three, four, five, or even six ribs. For obvious reasons the first and second, and the eleventh and twelfth are never interfered with. The periostium should first be divided longitudinally along the middle of the rib, and raised from the latter before removing it. The pleura should not be interfered with, except so far as necessary to enlarge the fistulous opening, or to make a new one in the most dependent position to secure proper drainage. There is usually very little hemorrhage. After the operation the cavity should be thoroughly irrigated so as to remove any blood which may have entered during the operation. The wound should be united, drained and dressing applied. In the after-treatment in addition to the constitutional remedies which may be indicated, such as quinine, iron, codliver oil, etc., the cavity should be regularly washed out with disinfectant solutions, and the healing process may be further facilitated by the occasional use of stimulating lotions containing tincture of iodine, sulphate of zinc, etc. A favorite plan in my own practice, is to add two or three drachms of tincture of iodine to the carbolic lotion to be used for washing out the cavity. When it is found the progress of the case comes to a stand-still, which may be determined by the repeated use of the probe or by frequent measurement of the quantity of fluid injected the operation may be repeated. Occasionally great assistance in closing the cavity may be derived by the application of an elastic bandage around the chest. In conclusion I would say that Estlander's operation may be regarded as a valuable procedure in the treatment of chronic empyema, and that useful lives may be saved by the operation.

ANGULAR CURVATURE OF THE SPINE OF OVER TWO YEARS' STANDING.—RECOVERY.*

BY J. CAMPBELL, M.D., L.R.C.P., E., SEAFORTH, ONT.

Mrs. B., æt. 33, a native of England, married, mother of one child, consulted me and gave me the following history. Over two years ago she felt pain and weakness in the back while washing. "Went to a medical man and told him my trouble, and drew his attention to a small lump on my back. He did not strip my body nor examine it, but told me I would never get better. Took medicine for two years from him and during this time the lump was becoming larger and the pain more severe. Had to lie in bed the greater part of the day and could do no work." Before coming to my office she had pains shooting down the legs and was harrassed by an irritative fever. On Sept. 2nd, 1883, she came to my office and appeared to be wretched enough. From her walk I suspected Potts' curvature at once. She had a pulse of 120, with a temperature of 101½°, with a careworn anxious countenance, indicative of pain. She told me that the shaking of the buggy gave her pain and that her husband had to make the horse walk the most of the way, a distance of 18 miles. Her tongue was furred and appetite gone, hence she felt pretty weak. Stripped the body and examined the spine particularly, and found displacement three inches in length and one in depth, involving the last dorsal and first and second lumbar vertebræ. I told her that the only hope of cure was in the application of Sayre's plaster of Paris jacket, or otherwise in lying still in bed day and night, and in supporting treatment, cod liver oil, hypophosphites, etc. She chose the jacket, and accordingly on the same day, with the assistance of Dr. Scott, of Seaforth, we put on Sayre's jacket, suspending her in the usual way. She said she felt complete relief from pain, and that she could jump off the doorstep of the house immediately. After the plaster hardened I put her upon syru of fer. iod. with cod liver oil and hypophosphites, advised good unstimulating nourishment and abundance of fresh air. The first jacket was kept on six weeks. She was free from pain until the jacket began to get loose, then pain returned again. Had the second jacket put on and felt relieved as before. Kept it on six weeks also; improving steadily. She took the medicine as before. During all this time she was able to ride around in a buggy, what she had not been able to do before, as every jar gave her pain. At the end of the six weeks we put on another jacket. She did not get the same relief from this one; whether it was our fault or not, could not say. She came back at the end of one week and had another put on, which proved more suc-

* Read before the Huron Med. Association, 8th July, 1884.

cessful, as she had complete relief from this one, and kept it on four months. During all this time she was getting stronger and was free from pain. The displacement never increased after the first jacket was put on. She came back at the end of four months and we put on the fifth jacket, which was on over three months with good results. She began working and felt pretty well. We now put on the sixth jacket, and did not see her again for ten months, but had a note from her husband stating that she was doing well. After wearing this jacket two and a half months she slit it up as we had previously directed, and laced it up in front like corsets. This enabled her to wash her body and keep herself clean. She continued taking the medicine and cod-liver oil, as previously mentioned, and improved all the time. She has gained fifteen pounds in weight, is cheerful, has no pain, and does all her own work. She came back on the fifth of June last for the purpose of getting us to put on the seventh jacket which we did. After a particular examination we arrived at the conclusion that consolidation had taken place. There was no pain nor tenderness on pressure or percussion over the displaced vertebræ, nor any other bad symptoms. She wished to have the jacket put on, she said, because she felt more comfortable with it than without it. It looked to her like an old friend, and she did not wish to part with it. The cure may be considered complete, and it is not likely that another jacket will be required or asked for even for friendship's sake. In fact we did not think the last was required, but put it on at her own request as we knew it could do no harm, and it is always better to err on the safe side at any rate.

Remarks.—My reasons for reporting this case are the following :—1st. I had a conversation with an old pupil of Dr. Stewart, of Brucefield (who introduced Sayre's jacket into this county, and who probably put on more jackets than all the doctors in it), and this gentleman said that he never yet knew of a cure from it, and he only knew of one case that was benefited by it. Now, I thought, if that be true, I must report my case, which is undoubtedly a complete cure. 2nd. When we consider the age of my patient, namely, 33 years, the cure is the more remarkable, as I believe it is conceded that the older the patient the less chance there is of receiving benefit, and that after twenty years of age the prognosis is rather grave. My patient was over two years ailing before her. The disease was very pronounced, a report shows, and the woman in a miserable dition, all of which things were against us, f will agree that the sooner a case of this ki diagnosed and treated the better. 4th. The was instant, which in itself was worth a great even if she had not recovered, and the imp ment, though gradual, continuous, until the summation so devoutly to be wished was f arrived at.

CARBOLIC ACID IN PURULENT AF TIONS OF THE CONJUNCTIVA CORNEA.*

BY G. HERBERT BURNHAM, M. B., F. R. C. S. M. R. C. S., ENG., TORONTO.

Late Resident Surgeon to Moorfield's Eye Hospital, L

A few years ago when Resident Surgeon Moorfield's Eye Hospital, London, I introc into ocular practice the use of the 5 per lotion of carbolic acid in gonorrhœal ophth Previous to this I had tried every variety of ment then recommended with a success not encouraging.

The deep transparent excavations of the c so frequent in this affection, so often follow perforation and prolapse of the iris, or deep filtrated ulcers which, through leaking in their give rise to falling forwards and adhesion iris to the posterior surface of the cornea not to be loosened ; or other cases in which the ation rapidly involved the whole cornea, ca destruction of vision, and at times of the self—all these terminations have I at dif times witnessed and seemed powerless to pr If the changes did not go so far, still I have kept on the wings of expectation, not kn with the arsenal of remedies then at my com what the outcome might be. These are a f the considerations which made me anxious a better and more reliable remedy. Now, a considerable lapse of time, I feel that I secured the desired remedial measure in ca acid. I have tested its merits in all the v forms of gonorrhœal ophthalmia, for instan

* Read before the Ontario Medical Association, Ju

that with much serous chemosis and swelling of the ocular and palpebral conjunctivæ; in that where the œdema is as great, but harder and denser; in that where the conjunctivæ of eyeball and eyelids and the sub-conjunctival tissue, are so fully loaded with exudation as to give the brawny, mottled look of diphtheritic ophthalmia. In fact, quite lately, I had a case, that of a young man, in whom the inflammation was the most violent I ever witnessed. The partly everted lids had the mottled, white and red look with inability to remove any of the infiltrations so characteristic of diphtheritic ophthalmia. When the tissues began to unload themselves, quite large pieces came away leaving excavated and bleeding surfaces. I value the treatment by carbolic acid so much above all the other varieties that I have ever employed, that I now use no other. Under its influence, the transparent excavations quickly heal, and, moreover, have never, since I began its use, progresssd to perforation, as formerly so often the case. The same may be said with respect to the other forms of corneal ulceration brought to our notice in gonorrhœal ophthalmia.

I, however, met with one form of corneal mischief, which I do dread, and against which I am not as well provided, as I could wish. This form is the deep, circumscribed infiltration of the cornea with the external surface unabraded. Here the morbid process goes on extending inwards till hypopyon comes. After this the external surface ulcerates, and then the part is so weak, that at once perforation of the cornea and entanglement of the iris, more or less complete, take place. The powerlessness of carbolic acid in this variety is due to its inability to reach the seat of mischief. The consequences of these cases being such as I have mentioned, have determined me to do *Saemisch's* operation when the opportunity is given me, and by so doing bring the abscess under the benign influence of this acid. This action I shall take though well aware of the great danger of incising the cornea in the midst of such a fierce purulent discharge. As is well-known in the worst forms of gonorrhœal ophthalmia the lids are so swollen and stiff, that only very partial or no eversion can be made. This prevents the proper application of other forms of treatment, such as strong solutions of nitrate of silver, the mitigated and pure stick. The carbolic acid lotion travels with great ease beneath the lids, and hunts out as it were all the obscure places. The way in which to make such a thorough application can, after a short time, be taught any moderately skilful nurse. These last truths I consider of great moment, and factors telling much in its favor.

The course pursued in the treatment of a case of gonorrhœal ophthalmia is as follows: The patient is ordered to bed; then there is placed at his bedside a large basin of cold water in which there is always kept a big piece of ice. The eye is to be bathed by the patient, or by the nurse, very frequently so as well to cleanse the eye. In the intervals cloths wet in the iced water are constantly to lie upon the closed eyelids. The lotion of a strength 1 in 20, is to be thoroughly applied *every hour*, the lids being as well everted as possible. I always apply the lotion very freely, and at the same time tell the patient to move the eyeball about, so as to give the lotion as free access as possible. These applications are to be made day and night. In consequence of this a nurse must be in constant attendance. The pain and smarting, which ensues after using the carbolic acid, last but a few seconds, and are succeeded by a feeling of comfort and relief. This is another point in its favor, and in direct contrast with the effects of the powerful caustics heretofore employed. As the discharge becomes thinner and more laudable, the 5 per cent. lotion is to be used every second hour, and during the intervening hour, the 2½ per cent., or 1 in 40, is to be applied. As the virulence of the affection goes on diminishing, the 1 in 40 may be used altogether. I do not employ the watch glass protector, the ingenious contrivance of Dr. Buller, of Montreal, for the sound eye. I tell the patient to lie on the side on which the affected eye is, and warn him of the danger of inoculation. I consider these measures to be sufficient precautions when using so frequently an application of such strong antiseptic properties. I look upon this lotion as the most effective and reliable remedy we have at our command in gonorrhœal ophthalmia; and the more I make use of it, the greater becomes my faith in its power tor good. The great *antiseptic* and *astringent* properties of carbolic acid place it, in my opinion, without a rival in the treatment of this inflammation.

This is its history in my hands with regard to the foregoing affection. I shall now mention it

with respect to other purulent affections, especially where the cornea is markedly implicated. One of the most dreaded sequels to a cataract extraction is purulent infiltration of the corneal wound. When this infiltration of the cornea has made its way to *Descemet's* membrane, and is also spreading in other directions in the corneal substance, and is associated with free purulent discharge, there is a feeling in the mind of the operator that the eye is as good as lost. It is in just such cases that I have more than once been completely successful, and have secured an unimpaired eye. I well recollect one case, that of an old and feeble man, an inmate of Moorfield's Eye Hospital, in whose eye on the third day after the operation, when union had taken place, infiltration of the wound set in. This, under the usual mode of treatment in such cases, got worse and worse. The infiltration alarmingly increased in depth and width, and the discharge became markedly purulent and copious. It was quite evident that improvement must quickly take place, or the eye would be lost. I now vigorously applied the 5 per cent. carbolic acid lotion. The result was that in two days the eye was out of all danger. Then, on examining the wound, there was to be seen a deep, broad excavation reaching to *Descemet's* membrane, with a ragged but healthy surface. The surrounding cornea was bright and clear. This excavation gradually filled up, and the patient went out with a good, serviceable eye. In those cases of kerato-iritis, where the corneal ulceration is extensive, this lotion has been used with most beneficial results. Here it is combined with the usual treatment of atropine, warm bathing and constitutional remedies. I have based all my remarks upon those cases in which the corneal inflammation was extensive, and associated with more or less purulent discharge, and where a new departure in treatment would show its usefulness, and enable a just conclusion to be drawn, in other words in test cases. If I think a weaker lotion than the 5 per cent. will answer the purpose, I may not at any time use the 5 per cent.

I feel that I am fully justified in strongly recommending the carbolic acid lotion in the various and kindred affections laid before you; for it has so often come out victorious in real test cases, and where previously non-success had too often been my lot. It is very necessary to use the *pure* carbolic acid, as any impurities give rise to such irritation and sometimes pain, as not only seriously to interfere with its full and proper application, but also materially to lessen its curative properties.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—Since reading an article in the December No. of the LANCET under the caption of "Professional Advertising," anent "our confreres down by the sea," I felt constrained to bring the following case of unprofessional conduct under the notice of the profession. Dr. A. is attending Mrs. S.; Dr. B., passing by, interviews Mr. S., and gains admission to the patient by the consent of the husband and without the knowledge of Dr. A Dr. B. (by force of habit perhaps) finds fault with the diagnosis and treatment of Dr. A, and by fair promises gains the confidence of the patient, and takes the case. Dr. A. visits his patient next day, is astonished at the conduct of Dr. B., and leaves in disgust.

This individual is also in the constant habit of visiting the patients of other medical men in their absence and without their knowledge, and attempts to justify himself in some cases on the flimsy pretext that he was requested to do so by the friends of the patient. He also habitually volunteers his advice and opinions concerning the patients of other physicians solely upon "hearsay" evidence. When called in consultation it is his custom, when opportunity presents, to remain behind and converse with the relatives of the patient after the attending physician has retired, and by inuendoes and insinuations infer that the case has not been properly treated, though no such inference was made in the presence of the attending physician. This conduct is of frequent occurrence in the practice of an old established physician here, who, to keep the vituperations and slanders against other medical men fresh before the public, is generally accompanied by his helpmeet.

Your, etc.,

A RESIDENT PHYSICIAN.

Cornwallis, N.S.

Reports of Societies.

SAUGEEN AND BROCK MEDICAL ASSOCIATION.

A meeting of the Territorial Association of the Saugeen and Brock Division was held in the town of Harriston, on the 8th day of January, 1885. The following resolutions were carried:

That all the proposed amendments to the Medical

Act, except clause 4, meet with our approval, and that instead of appointing a taxing officer, this meeting recommends the adoption of a uniform tariff for the whole Province, legalized by the Medical Council, signified by the Seal of the College, and the signature of the President, as provided in Section XVI. of the Ontario Medical Act.

That all Medical Students, after the year 1887, shall be required to matriculate and attend a course of at least two full sessions in the Arts department of some University recognized by the Medical Council.

That the members of this Divisional Association, now assembled, desire to express their approval of the course pursued by the Medical Council, and also of their present representative, Dr. Douglas, during the past five years.

Referring to the tariff lately issued by the Grand Trunk Railway, as regards medical attendance upon their employees and passengers: That the medical tariff rates issued by the Grand Trunk Railway be disapproved of, and that we recommend that no medical practitioner in this Division do sign it.

(Signed) R. DOUGLAS,
Chairman.
LLEWELLYN BROCK,
Secy. Treas.

Selected Articles.

THE METHOD OF EXAMINING ABDOMINAL GROWTHS.

The following clinic by J. Ewing Mears, M. D., Jefferson Medical College, reported in the *Med. News*, will be read with interest:

The presence of this patient to-day affords me the opportunity of speaking to you with regard to the methods to be pursued in the examination of patients suffering from abdominal growths. Having the patient prepared in this way and placed on her back on the table, the first step in the examination is inspection.

Inspection: The surface of the abdomen is inspected in order to ascertain whether it is uniform in shape. Its contour is observed and any enlargements or projections are to be noted. In practising inspection we should note not only any irregularities of the surface, but also the condition of the integument and any marks which may be found in the integument. For instance, your attention is called to a line which frequently exists between the umbilicus and the pubes. Formerly this line, which has a brownish color, was regarded as diagnostic of pregnancy, it being usually found, or almost as a rule, in women who are pregnant. This line is also observed in the patient before you and I have seen it in a number of cases of abdominal tumors. It is, therefore, not pathognomonic of pregnancy, but it also exists in other cases of enlargement of the abdomen. This line is due to a pigmentary deposit, and, so far as I can recollect, I have never seen any satisfactory explanation why it should exist. In a recent case of ovariotomy not only did this line exist prominently between the umbilicus and the pubes, but brownish spots were also found on different parts of the body, face, chest, and right side of the surface of the abdomen and on the lower extremities. In this case the patient stated that the brown line and spots appeared after the development of the growth. Further, after pregnancy to full term has occurred, the surface of the abdomen may be marked by cicatrices, which indicate undue stretching of the integument. I call attention to this point, since it has happened in cases which have been presented at the clinic, that pregnancy has occurred in unmarried females and the history of the case has been entirely opposed to any such condition.

Having learned all that we can from inspection, the next step in the examination is palpation.

Palpation: By palpation we mean pressure with one, two, or three fingers upon the abdomen, carrying this, if necessary, to some depth. In order to facilitate this manipulation, it is desirable that the patient should be directed to inspire and then make a forcible expiration. By this means the diaphragm is drawn up and the walls of the abdomen are relaxed and deep palpation can then be made. By means of palpation we ascertain whether the cavity of the abdomen or the cavity of the pelvis is occupied by a growth, and, further, whether the growth is hard, soft, or elastic.

Percussion: The next step is to percuss the abdomen. Percussion is familiar to you all as one of the methods employed in the examination of the thoracic cavity. Beginning in the median line, we percuss downward from the ensiform cartilage to the umbilicus and pubes. The patient is then turned on her left side and percussion made over the right lumbar region. She is afterwards turned on the right side and the left side percussed in a similar way. Percussion gives us an idea in regard to the character of any growth in the cavity of the abdomen. The percussion note obtained over the intestine is resonant, or even more than resonant, tympanitic in character. Over a solid tumor the percussion note would be dull or flat. Over a cyst containing fluid it would also be dull or flat. By percussion, therefore, we determine whether the abdominal cavity contains anything more than the

intestines, which emit a resonant or tympanitic sound on percussion, and the extent to which the growth occupies the cavity.

Auscultation: Auscultation is also to be employed in the examination of abdominal growths. In carrying out this procedure it is necessary to apply the ear to different parts of the surface of the abdomen. If there is any reason to suspect pregnancy, the ear should be first applied over the left side of the abdomen, midway between the umbilicus and the middle of Poupart's ligament. At this point the fœtal heart sounds can usually be heard, if the embryo occupies what is considered its normal position, that is, with the vertex to the left. Auscultation also enables us to determine whether or not the swelling which is present is due to aneurism, for by this means the presence of the aneurismal bruit can be determined.

The effort to determine *fluctuation* is the next step in the examination. By this is meant the production of a wave through the mass of fluid when the walls of the abdomen are struck or percussed. If one hand is placed on one side of the abdomen, and the other side is percussed with one or two fingers of the other hand, the movement of the fluid is felt distinctly. This wave differs much in amplitude according to the density of the fluid and also according to the character of the cyst in which it may be contained. If the fluid is thin and limpid, the wave is long; if the fluid is very dense and viscid, the wave is short. The ability to determine these differences is acquired largely by experience I simply give you here general statements in regard to the differences in the fluctuation wave in fluids of different density. Fluctuation also enables us to a certain extent to determine whether the fluid is contained within a cyst or in the general peritoneal cavity. This also requires some experience in order to insure accuracy. Fluid in the general peritoneal cavity gives in fluctuation a wave which pervades the entire cavity, and this can be felt by placing the hand on different parts of the surface. When, on the other hand, there is even a thin cyst wall it is sometimes possible to distinguish the limit of the wave movement. Fluctuation can also be developed by introducing a finger into the vagina, and if the cyst occupies the pelvic cavity, fluctuation can be obtained by percussing the abdominal wall and feeling the wave with the finger in the cavity of the vagina.

I desire also to call your attention to a wave-like movement which is sometimes obtained on percussing the abdomen, and which is known as the fat wave. This wave is found in patients with very fat abdominal walls, this fat being loosely held in the meshes of the fascia. It is important that this be borne in mind, for errors in diagnosis have been made by the confusion of this wave with that of fluctuation.

We have so far examined the abdominal surface. It has been examined with the eye so as to determine its contour and outline. It has also been examined by palpation and percussion. The ear has been placed on the surface and auscultation has been performed. The effort has also been made to determine whether the fluid is contained within the peritoneal cavity or in a cyst in the cavity. This has been done by eliciting the fluctuation wave.

I might say, in addition, that it is desirable to employ mensuration — that is, measuring the enlargement This can be done by a tape-measure passed around the abdomen at the level of the umbilicus. Then, at the point of the ensiform cartilage, also at the point of greatest enlargement, which is usually below the umbilicus, and a measurement may also be taken just above the pubes. In this way the circumference at these various points can be ascertained and recorded. It is also important to note the distance from the ensiform cartilage to the umbilicus and from the umbilicus to the pubes. If it is necessary to examine the patient from time to time, these measurements can be repeated in order to determine the variation in size.

Having completed the external examination, we are now prepared to make a vaginal examination. I take the opportunity of saying at this point that no one would be justified in undertaking abdominal incision without completing any examination which has been made by a vaginal examination. I can recall at this moment one case in which this step was neglected and the abdominal cavity was opened and a pregnant uterus found. A vaginal examination in this case would undoubtedly have revealed the existence of pregnancy, and the patient would have been saved the rather dangerous operation of abdominal incision. For the purpose of a vaginal examination the patient should lie on her back and should afterwards be changed to the side. The finger, well anointed, should be passed into the vagina and at once seek the cervix. Having examined the cervix, the finger should be swept around the neck, and as it is withdrawn palpation should be made anteriorly, laterally, and posteriorly. Then bimanual examination should be practiced, with the finger of the right hand in the vagina, pressure being made over the surface of the abdomen with the left hand. In this way information can be obtained in regard to the connection of the growth with the uterus. Other points of information which can be obtained in this way are the following: A cystic tumor occupying the pelvic cavity can be felt through the vaginal wall. A solid tumor can be felt in the same way. So with the finger introduced into the vagina, the occupation of the pelvic cavity can be determined through the vaginal walls. As I have already stated, fluctuation can be obtained with the finger

in the vagina, percussion being made on the surface of the abdomen with the other hand.

It is also necessary to introduce the sound into the uterine cavity in order to determine the condition of the uterine canal. It is desirable that beginners in performing this operation should use the speculum. After years of experience, one may be enabled readily to introduce the sound without danger into the cavity of the womb without a speculum, the finger of one hand being introduced into the vagina and placed on the cervix and the sound being carried along this as a guide. There are so many dangers, however, which present themselves in the introduction of the sound in cases of uterine tumors, that it is desirable to use the greatest care in the introduction of the sound into the canal. It should not be forced, but the way should be felt. It frequently happens that there are displacements of the uterus by reason of the pressure of the growth, whether this be solid or cystic in character. With regard to the presence of cystic growths, the information obtained by passing the sound into the uterus relates rather to the mobility of the uterus and to the fact of its being drawn up from the cavity of the pelvis or forced down into the cavity. On the one hand, we may assert with reasonable accuracy that adhesions exist if the uterus is found to be drawn up into the cavity of the pelvis and held in a fixed position; and on the other hand, we may infer that the cyst is impacted in the cavity of the pelvis, if the uterus is in a state of flexion, either antero cr retro, and is immovable in its position. In fibroid growths, especially of the submucous and mural varieties the sound will give valuable information as to the seat of the fibroid tumor.

With the speculum we can ascertain the color of the mucous membrane of the vagina and the color of that covering the cervix. This is regarded as a matter of importance, as in the pregnant female the color is of a purplish hue, which is thought to be diagnostic. Another point to be ascertained with the finger in the vagina is the condition of the cervix, as to softness or hardness.

In addition to the examination by the vagina, it is sometimes desirable to make an examination by the rectum. By this means the existence of growths which cannot be readily reached in the vagina can be determined. An enema should be administered beforehand in order to unload the lower bowel.

It is also well to complete the examination by the introduction of the sound into the cavity of the bladder. With this instrument in the bladder, and the finger in the rectum, bimanual manipulation can be made which will assist in the detection of tumors occupying the pelvic cavity.

In order to illustrate the points to which I have alluded, I shall next examine the patient now upon the table. She has been prepared by the removal of all unnecessary clothing and of all constrictions around the waist. The abdomen is exposed, and on inspection we observe that it is irregular. In the median line there is a projection, and on the right side there is another. The observance of two irregular points upon the surface gives us certain information in regard to the natuie of the growth which occupies the cavity of the abdomen. It excludes certain conditions. For instance, pregnancy. In pregnancy there is a uniform enlargement of the abdomen, and the surface is not irregular as in the present instance. Inspection does not enable us to say whether these irregularities are due to pedunculated fibroid tumors or to exogenous cysts forming part of an ovarian cyst, but it does enables us to say that this is not a case of pregnancy and not a case of simple cyst.

Palpation is the next method to be employed. By making pressure with two or three of the fingers over different parts of the swelling, I can easily feel beneath the abdominal wall a hard, resisting mass which is not elastic. This would seem to indicate that the growth is solid and not cystic. Palpation elicits the same sensation over all parts of the growth. We cannot say positively from this examination that this is not a very dense multilocular cyst. You may be able, after much experience, to determine very slight shades of difference in the elasticity, which can be obtained even in cases of dense multilocular cysts. So far as I can ascertain from palpation, I am inclined to believe that we are dealing with a solid tumor and not a cyst. Not only do the fingers determine the presence of a hard, unyielding mass, but those projections which were noticed on inspection can be further outlined. Slightly to the right of the median line is a large mass which appears to be attached to the uterus by a broad pedicle. On the left is another mass, and below the tumor on the right there is a small mass which seems to be somewhat moveable. This would seem to indicate that these growths are fibroid tumors which are attached to the body of the uterus by either broad and short or narrow longer pedicles. In the former case being called sessile and in the latter pedunculated or pedicalated growths.

You will observe that the brownish line reaching from the umbilicus to the pubes, which has been referred to, is present in this case.

Next, I shall practice percussion. Beginning at the ensiform cartilage, and percussing in the median line, there is, as you observe, resonance down to this point, about two and a half inches above the umbilicus. Here the sound suddenly changes into that of dulness or flatness. As I pass downward in the median line, the same flat sound is elicited below the umbilicus. As I pass on either side of the median line from the point before mentioned, the dulness is found to exist there also. The patient is next turned on the left side, and percussion performed over the right lumbar region and

lateral side of the abdominal cavity. At this point we find the dulness which belongs to the liver, and as we pass downwards we reach the resonance belonging to the ascending colon. Turning the patient now upon the right side and percussing over the left side, we find in the posterior part of the lumbar region, the resonance depending on the presence of the descending colon. As we come to the median line, the sound becomes dull or flat, showing that this mass projects more into the left side than into the right side of the abdominal cavity.

Testing for fluctuating, I find it impossible to obtain any wave. We can therefore say that there is no fluid, either in the abdominal cavity proper or in any cyst contained in the abdominal cavity.

Continuing the examination, I place my ear over the abdomen at the point which I have before mentioned. I am, however, unable to hear any sound which may be regarded as indicating the presence of a fœtus in the uterus or any aneurismal bruit which would be found in dilatation of the aorta. Auscultation, therefore, gives altogether negative signs in this case.

Examination per vaginam shows that the uterus is small. The cervix is slightly elongated and that of a woman who has not been pregnant. The uterus is fixed and immovable in a position of marked retroflexion. Palpation through the vaginal walls reveals the presence of hard, unyielding masses. These, so far as can be ascertained, are attached to the body of the uterus. Owing to the displacement of the uterus, it is impossible to introduce the sound completely. It simply passes into the cervix, but not beyond the internal os.

Rectal examination has not been made, nor has any examination by the bladder been made, as the symptoms were sufficiently prominent and characteristic to enable us to arrive at a conclusion without employing this manipulation. In any case of doubt, however, it is necessary that examination by the rectum and bladder should be made as before stated.

Having passed in a systematic manner through the different steps of the examination, we are enabled to arrive at a conclusion in regard to the nature of this growth. In other words, we are prepared to make the diagmosis. From what I have seen, and from what I have felt, I am prepared to say that we have here fibroid tumors which are of the subperitoneal form. Whether the uterus itself is involved to any great extent cannot be positively determined, owing to the impossibility of introducing the sound. It is, however, quite possible that in addition to the subperitoneal form of fibroid tumors there is also the mural form or that in which the body of the uterus is affected.

Before passing to the question of treatment, I would say that there are three varieties of fibroid growths, or if you choose to call them so, of fibromyoma or fibro-myomatous growths. These varieties are the subperitoneal. in which the tumors lie beneath the peritoneum; the interstitial or mural, in which the tumors are located in the substance of the uterus itself, and the submucous, in which the tumors are situated beneath the mucous membrane of the uterine canal. In the subperitoneal variety the tumors project from the surface of the uterus, being covered with a layer of peritoneum and sometimes attached to the body of the organ by a broad aud short pedicle, in which case, as I have said, they are called sessile growths, or by narrow and long pedicles, in which case they are called pedunculated growths. In those eases in which the pedicle is small and long, the mass can readily be moved about the cavity of the abdomen. Not only so, but it falls about if no adhesions exist, as the patient changes her position from side to side or rises from the recumbent to the erect position. In the case of mural tumors, which, as already stated, occupy the substance of the uterus, the organ is uniformly enlarged. Where they exist without the presenee of subperitoneal or submucous tumors, the uterus is uniformly enlarged, as is found in pregnancy. In the submucous variety the growths form beneath the mucous membrane and project into the cavity of the uterus. Sometimes they get into the canal, and the contraction of the muscular fibres forces them on down until they escape from the cervix, forming what are known as polypi, the pedicle being in these cases elongated so as to permit the growth to pass into the cavity of the vagina. Frequently these submucous fibroid tumors are very large, and they do not pass into the canal and become pedicalated, but distend the cavity of the uterus and change the direction of the canal.

The symptoms in the submucous and mural varieties of fibroid tumours are largely connected with the menstrual flow, and they relate to an increase of the flow. I have had some patients who have lost enormous amounts of blood at these periods. This is a prominent symptom and should always lead to a suspicion of this form of growth. Hemorrhage at the menstrual period is not so marked in the mural as in the submucous variety. This symptom may be entirely absent in the subperitoneal variety of fibroid tumors.

I next come to the question of treatment. At the present day, various methods of treatment are practised. In the first place with regard to medication. Mural and submucous growths are amenable to treatment by means of such remedies as ergot, which, by contracting the bloodvessels of the organ, diminish the nutrition, and in that way limit the growth of the tumor. There has been sufficient experience obtained in the use of ergot and its preparations to warrant the conclusion that these forms of growth can be positively limited. Whether or not they can be ultimately removed, is still a question, but their growth can be checked. Ergot

is not of as much value in the subperitoneal variety, especially in the pedunculated form, where the pedicle is long and narrow. It may be of some service where the pedicle is broad, as in the sessile growths, and where the effect of the remedy can reach the bloodvessels of the attached mass. The muriate of ammonium was employed by the late Dr. W. Atlee. who regarded it of value in the treatment of fibroid growths of the uterus.

After these remedies, operative interference may be employed, but there are two very important questions or conditions to be considered before any operation is to be decided upon. In the case of fibroid growths in which the menstrual flow is so great as to drain away the life of the patient, it may be justifiable to interfere with the knife. There is also another condition which would warrant operative measures, and that is the enormous size of the mass, making it a burden to the patient too great to bear.

In regard to operative interferences, the menopause can be anticipated by the removal of the ovaries. If any operation is to be performed, the removal of the ovaries, which is much less dangerous than extirpation of the uterus, is the one to be adopted. There are to my mind very grave objections to the performance of operations for the removal of fibroid masses which involve the body of the uterus or which are attached by very broad pedicles to it, and which are adherent to the viscera or abdominal wall.

A patient with a uterine fibroid can enjoy life and the growth can exist indefinitely without interfering with health. I have at this time under my care a number of patients suffering from fibroid tumors in whom I have practised the hypodermic injection of ergotine, or the aqueous extract of ergot, for a number of years. In one of these cases, I have used ergotine for the past eight years. Measurement of the abdominal enlargement in this case shows that the growth has not increased. It has, on the other hand, not markedly decreased. The patient does not lose much blood during her menstrual period, and is not rendered uncomfortable by the presence of the tumor. She is able to take part in all the enjoyments of her home, to ride out in her carriage, and to enjoy the company of her friends. I am quite sure that if I were to interfere in this case with a surgical procedure, I should terminate the life of my patient. In another case, in which I used ergot for three years, a most desirable result was obtained. In this instance, the growth was of the submucous variety. After the lapse of nearly three years, I observed that the mass was softening; and on palpation and percussion, fluctuation could be distinctly obtained. I also examined the mass from the cavity of the uterus, and found that there, too, it was softened, and fluctuation could be obtained. I therefore determined to incise the wall of the eanal, which I did, and a mass of offensive fluid escaped, containing broken down débris of muscular and fibrous tissues My patient suffered greatly from pyæmic symptoms, and was very ill for a number of days; but by the vigorous use of antiseptic methods, washing out the cavity with antiseptic agents, as the solution of carbolic acid, surrounding her with the best hygienic conditions, and by the employment of tonics and stimulants, I was able to carry her through this critical period occupied by the evacuation of this large cavity formed by the breaking down of the tumor. Other instances of this kind have been recorded in which the effect of ergot was markedly seen. I can only explain this transformation of the solid growth to the fluid or semi-fluid condition by the cutting off of the nutritrition of the growth, and the production of positive gangrene.

There are instances on record in which incision of the lining membrane of the canal has been made and ergot afterward given. In this way submucous fibroid tumors have been delivered. When the delivery has not been complete, the surgeon has interfered, and has removed the mass by cutting away portions of it at different times. This operation is attended with many dangers. Some of these dangers result from septic infection and shock. There is also the danger of the occurrence of hemorrhage.

From the examination of the case before you, the the treatment which I should adopt, would be the long continued use of hypodermic injections of ergotine, and this failing, the performance of oöphorectomy. I may say, in regard to the hypodermic injection of this remedy, that the injections should be made in the abdominal wall; and in order to avoid the occurrence of abscess, it has been my practice to carry the needle of the syringe deeply into the tissues, not stopping until the muscular structures have been reached. In none of the cases in which I have used ergotine in this way have I met with abscess. As a precaution I have frequently painted tiucture of iodine around the puncture made by the needle. The form of ergot used is that known as Squibb's aqueous extract, made in a solution, the strength of which is one grain to the minim. Of this solution, I have given 25, 30, and 35 minims without producing any undesirable symptoms.

THE TREATMENT OF HYPERPYREXIA BY COLD APPLICATIONS TO THE ABDOMEN.

In a recent clinic in the *Pennsylvania Hospital* reported in the *Col. and Clin. Record* Dr. Da Costa gave the following interesting cases:

The case now before you is one of typhoid fever, only remarkable for a sustained high temperature

persisting in spite of various remedies. The temperature in the morning was 103° F., and occasionally 102, in the axilla, but for nearly a week the temperature remained at 104.8°. As there had been no marked exacerbations in the temperature, we looked upon it as a case of grave character, on account of the sustained fever. With reference to the intesinal lesions, as manifested at least by the occurrence of symptoms of bowel disorder, they were not severe: he had only three or four stools a day. The eruption was well defined, but there is nothing in the case to which I wish to call your attention besides the temperature record.

Let us see his present condition. His temperature this morning is 100½°; last night it was 101½°. I, therefore, think that the disease is yielding. The bowels have not been opened for thirty-six hours, and tend to constipation He is very deaf, but obeys intelligently when I can make him hear His tongue is moderately dry and slightly fissured; it is tremulously protruded. I want you to observe this cracked, dry condition, with the yellowish coating upon it; though it is not very dry, it still impresses you as a dry tongue. His abdomen is rather prominent and tender; a few spots of eruption are still visible upon the surface. There has been some atony of the bladder, so that the urine has had to be frequently drawn with the catheter. Examining his heart, I notice that there is almost complete extinction of the first sound; it can just barely be heard. The pulse beats only one hundred in the minute, even with the excitement of coming before you; but, as I see upon the record, it has never been a rapid pulse. It is compressible, but has decidedly more volume than it had a few days since. His general condition is improving with the reduction in the temperature. He has been taking dilute muriatic acid (gtt. v) and turpentine (ɱ x) every two hours. He also takes twelve grains of quinine daily; and six ounces of wine and six of whiskey: therefore he is freely stimulated. His food consists of milk and beef tea, two pints of each in the twenty-four hours.

Now I have given you a statement of his treatment, with a single exception, and that is what I wish to develope in our discussion, viz.: the treatof the high temperature. When I found that this man had, a week ago, an evening temperature remaining persistently at 104°, I tried to reduce it by large by doses of quinine, sixteen grains daily; and on one day he took ten grains morning and evening. He was also frequently sponged with cold water. The effect was but slight; the temperature remained high. I then directed that cloths wrung out of ice water should be laid upon the abdomen until the desired result was obtained. It was found that this was more efficient, and the temperature was at once reduced to 100°, so that by this means we were enabled to keep the temperature within bounds, and thus to gain time. We disgussed the expediency of putting him in a bath, but, as he was very weak, and the bath room is some distance from his bed, rather than subject him to the risks of so much handling, we yielded the point, though, if the bath had been more convenient, I would have preferred it. I wish to call your attention especially to the use of ice water applications to reduce temperature, as a substitute for the large doses of quinine, and cold baths, which are not always convenient. It is a most instructive case. Indeed, I consider that the man's life has been saved by this means. Taking into consideration the rising temperature and the failing circulation, as shown by the impaired heart sounds, it did seem likely that the case would not get well. I would call your attention to the fact that in this case the quinine failed to reduce the temperature. It does not often fail, but it did here.

Another point is this deafness which you have observed. I almost had to shout to him before he put his tongue out. The resident physician tells me that he has been so since he came in; therefore it was not the effect of the quinine. Deafness in typhoid fever is not uncommon, and I may state that it does not contradict the use of quinine; by no means. It is due to the state of the blood and the impaired nervous system. We also note here that he has a constant tendency to stupor, is rather drowsy and heavy; he sleeps well at night without opium; he has not been delirious, and has not suffered with headache. The deafness, therefore, is the only symptom referable to the nervous system. There is very little if any, jerking of the tendons, or tremor.

Now, gentlemen, with regard to the treatment I shall make a slight modification. Quinine need only be given in tonic doses. We will order him to take eight grains daily. The dry tongue indicates that the turpentine is still useful; the amount of acid is so small that it does not make much difference whether it be continued or not, but, as it is grateful to the stomach and aids digestion, we will continue it also. Sponging of the general surface with water will be done several times a day, as heretofore; and if the temperature again rises we will return to the ice water applications. With regard to the amount of stimulant, although it seems large, yet I will not reduce it, on account of his dry tongue and weak heart. I think that just now it would be dangerous to make any change.

PILOCARPINE IN ACUTE ERYSIPELAS.

I have here a case to show you which I think will interest you, as it brings out rather a novel treatment of erysipelas. I intended to exhibit this to you this morning as a case of erysipelas, but I find that the erysipelas has gone. I, therefore, can only speak of the treatment, which has proved more quickly efficacious than I supposed it would.

This man B. K., 32 years of age, a fireman, was

admitted only yesterday. This is the record upon admission: "He says that he was quite well yesterday (November 12), but he did not go to work, as he was celebrating the election. In the evening, according to his statement, he was not drunk, though he had been drinking a little, and became engaged in a very earnest political discusion, when some one, equally earnest, struck him in the right eye, making a bruise on the cheek and a small lacerated wound on the eyebrow," the evidence of which you may see for yourselves. The man at that time was quite well, although under the influence of liquor. "During the night he had much pain in his eye, and in the morning the eyelids were œdematous and the cheek likewise swollen, red and burning." When he applied for admission the inflammation was confined to the right side of the face, but it spread rapidly, and the same afternoon both eyes were closed. It is worth adding this to his history that he had slept out all Wednesday night after receiving the injury. He was admitted on Thursday morning, with erysipelas of of the upper part of the face, which was rapidly spreading over the brow. His pulse was 80; temperature, 102.8°; respiration 22. The urine was examined, with a negative result. He was ordered tincture of the chloride of iron, twenty drops every three hours, but only received one dose; as the disease was rapidly spreading, and something was needed to make a prompt impression, I used another and more active agent. This was not the first case in which I had used this remedy, but it was the first in which I obtained such rapid relief. He received, hypodermically, one-sixth of a grain of the muriate of pilocarpine. The result was remarkable. Here is the temperature record: the temperature fell from 102° to 99¼°. He sweat profusely for an hour and a half, and there was no further development of the erysipelas; not only did it not spread further, but what did exist quickly subsided. No local treatment was employed, not even cold applications; therefore, whatever success was obtained was from the pilocarpine.

I call your attention to this treatment of erysipelas. I said that it had not been my first case, although it was the most striking case I have seen. As long as five years ago I used jaborandi in the treatment of erysipelas until sweating was produced, and, I thought, with the result of checking further development. In one case, with high temperature the disease had already made some headway, and and did not subside so quickly. Under the use of iron the disease had not been controlled, but the fluid extract of jaborandi, given every two hours, checked it. I have since used the jaborandi in connection with the iron at times, with good results. This is, therefore, not a new treatment with me, as I have used for some time. Jaborandi and pilocarpine, its active principle, are, of course, similar in their effects.

I have called your attention to this treatment, not because I believe that it will be followed by the same result in every case, but because it is worthy of a trial. If you get a case of erysipelas in its beginning, use pilocarpine. It has saved this man a long and dangerous illness, and, as he had been drinking, as he said he had, the results might have been serious. In the use of this treatment it should be borne in mind that, in order to be fully effective, profuse sweating must be produced.

MALARIAL SYMPTOMS FOLLOWING SURGICAL OPERATIONS.

M. Verneuil has already called attention to this subjcct, which is one that should be of special interest to New York surgeons, seeing that it is the fashion in this city to ascribe to "malaria" a number of obscure symptoms which can not be conveniently assigned to any other cause. Dr. Baruch has alluded to the fact that much of the "malarial disease" of New York is wrongly so called, since the most striking phenomenon of this affection, its periodicity, is frequently absent. But, while he insists upon the desirability of making a positive diagnosis to that effect only in cases of frank intermittent fever, perhaps he does not lay enough stress upon the peculiar masked forms of the disease which undoubtedly abound among us.

It is a common experience with our surgeons to meet with sudden and unaccountable elevations of temperature after operations, elevations which can not be attributed to the condition of the wound, or to the occurrence of inflammatory complications. This phenomenon is apt to cause no little uneasiness, especially in peritoneal surgery, in which a sudden rise of the index at an early period is well known to presage the invasion of peritonitis. But this occurrence is not confined to major operations, since trifling manipulations of the uterus, such as trachelorrhaphy and curetting, may be followed by fever, which is equally alarming, being suggestive of parametric inflammation. Now, a peculiarity of this rise of temperature (which is often accompanied by a rapid pulse and a good deal of constitutional disturbance) is that it observes a sort of periodicity. In the morning the thermometer will register as usual in uncomplicated surgical cases, while toward evening, on visiting his patient, the attendant will be surprised, and often alarmed, to find a reading of 103° or 104° F. The wound is examined, the patient is interrogated, but, aside from a confession of restlessness and nervousness, nothing can be elicited to explain the fever. There may or may not have been a preceding chill; generally it will not have been recognized. As the patient convalesces, these mysterious symptoms will disappear. With the adminstration of full doses of quinine, according to the ordinary rules observed

in using this drug for the cure of intermitent fever, the attacks will generally be cut short in two or three days. In most of the cases which have fallen under our observation, either a history of malarial exposure could be obtained, or subsequent observation of the patient after complete recovery from the operation showed that the disease was present.

The interesting point in this question is, what peculiar condition of the system is induced by a surgical operation whereby latent, or masked, malarial disease becomes actively developed? This we do not pretend to answer. It is akin to the sudden appearance of delirium tremens after injuries. The practical interest of the subject lies in the inference that the surgeon should not allow a rise of temperature *per se* to disquiet him—indeed this is only another phase of the question which Nothnagel has lately brought into prominence.—*N. Y. Med. Jour.*

Excision of the Knee in preference to Amputation in certain Deformities of the Leg.—Dr. Stephen Smith, of New York, read a paper with this title, at the New York State Medical Society meeting, December, 1884. There was a certain class of cases in which the question of excision at the knee, or amputation at or below that point, was to be determined. They were those cases in which the leg was rendered useless for locomotion, closely allied to those cases of deformity and displacement in which there was chronic inflammation, and the weight of the body could not be borne on the limb. The solution of the question would depend upon two points: the comparative safety of the two operations and the comparative usefulness of a stump after an amputation at the knee-joint, and at a point immediately above or below that point. Out of fourteen cases of partial excision, but two patients died, which was a mortality of only two per cent., showing a difference of eight per cent. in favor of excision. In a large collection of cases, amputation below the knee gave a mortality of thirty-four per cent., and amputation above the knee gave a mortality of sixty-three per cent. Although these figures showed that excision was by far the less dangerous, for purposes of comparison he would place them on the same footing. Perhaps the greatest weight of authority on the question had been furnished by the late Dr. Hudson, of this city, who was employed by the Government for several years. Much as he favored artificial limbs, he always regarded an ankylosed knee as more serviceable than a stump to which an artificial limb might be adjusted. In the light of these facts, we might formulate conclusions in regard to these operations as follows: That excision at the knee-joint was quite as safe as amputation above or below that joint; that excision of the knee-joint was to be preferred to amputation, by which the leg was rendered useless.

Dr. S. W. Gross, of Philadelphia, took it that excision of the knee-joint was not the proper operation in all cases of deformity of the knee; for instance, in cases of ossification or synostosis of the joint he saw no necessity of resorting to excision at all. In such cases it had been his practice, and that of his father, the late Professor Samuel D. Gross, to make an incision across the knee, and break up the osseous union with a chisel. Then the patella could be separated from its adhesion to the femur by force applied to it through a towel interposed. Then, on account of the danger of rupturing the popliteal artery, it was not safe to attempt to straighten the limb entirely at once, but it was best to bring the foot down only so far as was necessary to make the toes touch the floor—the heel, he thought, should swing about an inch above the floor. Even this it was safer to accomplish gradually, at several operations, the patient being anæsthetized each time. This operation, he thought, should be more widely practiced in preference to excision, as had been taught by the late Professor Gross, in his "Surgery." In regard to the statistics brought forward by the reader of the paper, he would say that they had been materially changed within the last five or six years, and no surgeon who resorted to antiseptic precautions would expect to have a mortality of more than three or four per cent. after amputation of the leg. —*Medical Record.*

Trephining in Mastoid and Tympanic Disease.—Dr. W. J. Wheeler, of Dublin, at the conclusion of an article on this subject, says:

Of the 35 cases in which the trephine was used, 4 terminated fatally, while the result in the other cases has not been reported; in the total number of cases, the results of which are differently specified, 17 per cent. were fatal, and 21 per cent. successful. Buck has collected 37 cases of suppurative inflammation in which the cases were left to nature (expectant treatment); 34 were fatal. It will be readily seen from the foregoing that the operation of trephining for mastoid disease is a fairly successful one, and, on the other hand, that, from the expectant treatment in suppurative inflammation there is little to look forward to but a fatal result. That the operation should be be practiced early is a self-evident fact; it is useless when pyæmia, meningitis, or phlebitis of the sinuses has appeared, although the first cerebral manifestations should not intimidate the surgeon from operating, and I doubt not but that good service will be done toward the patient by his attendant who advises operation even where no bone disease existed, but when the discharge from the tympanum has lasted for *a lengthened period*, and has not yielded to other treatment, such as syringing and enlarging the opening of the membrana tympani if necessary. Setons and issues I believe to be of little use, for

although only the mucous membrane may be engaged, yet we know that a blow on the mastoid process, a severe cold, a depressing illness, may cause disease to advance to the bone, pyæmia may ensue, or death by general cerebral irritation, without the formation of abscess. A well-accomplished operation will always give free vent to pus when existing, and prevent it passing to the brain through some of the numerous channels I have recorded, and will thus save the patient. I must deprecate the operation recommended by Dr. Bagroff—namely, the use of the gouge and galvano-cautery over the mastoid process; such procedure, as it appears to me, would be likely to set up irritation and inflammation. Unless, indeed, the suppuration is comparatively superficial, or discharging through a fistulous opening, I would not select to operate over the mastoid process; there one cannot remove the entire portion of the bone, on account of the proximity of the lateral sinus, and so cannot expose the dura mater, to do which I hold is very essential.

The site I would always select for operation, with the exceptions as above named, would be such as to place the lower border of the trephine on a level with the external auditory meatus, and anterior to a line dividing vertically the mastoid process. By adopting this course there will be no danger of wounding the lateral sinus, the tympanum and mastoid cells will be opened, giving full exit for discharge, the dura mater will be exposed, and should pus exist between it and the cranium, there will be ample freedom for its escape.—*Dublin Journal of Med. Sc.*, October, 1884.

DISINFECTANTS.—At the close of a paper on this subject, Dr. W. J. Miller, of Dundee, draws the following conclusions:

"1. It is very doubtful that any efficient disinfection of a room can be practised while it is occupied. Nevertheless, it is possible that the presence of a disinfectant, though not in sufficient concentration to kill contagium, may, by long continuance of operation, weaken it, and, if microzymes be the contagium, may so lower their vitality as to impair their power to reproduce their kind. A certain degree of probability is given to this by Prof. Tyndal's observation of the effect of continuous heating in sterilizing putrescent liquids, which led him to conclude that there is a period in the life-histoy of these minute organisms when they are especially vulnerable. It is therefore, in the direction of good to employ some disinfectant during the progress of the case, and there is none equal, either in efficiency or in simplicity of application, to sulphur. It is exceedingly convenient in practice to use sulphur pastiles, as introduced by Dr. Littlejohn, each of which contains twenty-five grains of sulphur, one or two being used at a time, according to the size of the room. This should be done several times a day.

"2. The skin of the patient should be sponged several times a day with diluted acetic acid, by preference with the aromatic. This is especially applicable in scarlet fever, effectively disinfecting the desquamating skin. I only mention the method of inunction to condemn it emphatically. The strength of the solution must be regulated by what is found agreeable to the patient; a 1 to 20 solution of the aromatic acid, which has been referred to, is generally too strong.

"3. For the final disinfection of the sick room nothing equals sulphur. But it must be thoroughly applied. The Dundee sanitary authority uses about three pounds of sulphur to a room about ten feet square, carefully closing all apertures by which the fumes can escape, aud leaving the room shut up for about four hours.

"4. For disinfection of clothing, etc., the method followed here is exposure to a temperature of about 250° for three hours in a specially constructed chamber, the air being also charged with the fumes of about six pounds of sulphur. It is scarcely possible that any contagium can live through such an ordeal.

"5. Excreta of patients are best dealt with by Dr. Dougal's method—namely, mixture with hydrochloric acid diluted to 1 to 20. He has proved that this solution does not injure the metal fittings with which it comes for so short a time in contact. Clothes may also be thoroughly disinfected by this agent, and without injury

"6, For hand disinfection, carbolic solutions 1 in 20, acetic acid, and sulphurous acid, are almost certainly thoroughly effective.

"7. The question of disinfectant inhalations for lung disease, especially phthisis, demands a longer consideration than can here be given to it, but, when we consider that vaccine which has been exposed for three hours to air saturated with creasote vapor, and similarly for four hours to the vapor of eucalyptus, retained its infectivity unimpaired, that the germs to be acted on are far in the recesses of the air-vesicles, and that the inhaled disinfectant can only reach them in very weak dilution, if indeed it reaches them at all, it appears to me, although it is very disappointing to arrive at such a conclusion, difficult to place much confidence in this therapeutical expedient."—*Practitioner*, Oct'84.

THE PAINLESS EXTINCTION OF LIFE.—The *Med. Press and Circular* states that: Dr. Richardson's lecture on "The Painless Extinction of Life in the Lower Animals," at the Society of Arts last week attracted a very large audience, among whom we noticed many members of the profession. The lecturer prefaced his subject by stating that he had, at the request of the Committee of the Dog's Home, Battersea, constructed a lethal chamber for the painless extinction of the life of dogs which nobody owns, which must of necessity be destroyed.

He put the process into operation in May last by subjecting thirty-eight dogs to the fatal vapor, and all passed rapidly into sleep and from sleep into death. Since then from 200 to 250 dogs per week have been painlessly killed in the chamber. The number struck us as unusually large, and we were almost tempted to ask what the anti-vivisectionists were about, and why they so cruelly abandoned so many of their pets—7,000 in a few months—to starvation or to the tender mercies of the police and the uncertainty of prussic acid. The numbers, however, Dr. Richardson said, had been exceptionally large and the experimental results so entirely practical and successful that he felt the time had come for him to place them fully before the public. The process at first was not unaccompanied with difficulties—first, in determining the anæsthetic to be employed, and next as to the most efficient form of chamber in which the animals should be exposed to the lethal gas or vapor. Out of a list of twenty-two anæsthetics he had selected four of the best known among them, which he subjected to a careful series of trials, and of these he finally selected carbonic oxide as the easiest to deal with and the least expensive. The lethal chamber is filled with gas by an ingeniously constructed Clarke's stove.

As to the painlessness of the death of the dogs, there can be no doubt whatever, and Dr. Richardson firmly believes that the same method might be used for the destruction of those animals which supply us with food. Indeed, he has already tried it with sheep, which are put down to sleep with the greatest rapidity before being slaughtered, and it has been found that the carbonic oxide exercised no prejudicial influence over the flesh of the animals, nor did it unfit it in any way for the market as food.

The same process is found equally applicable to swine, calves and fowls, so that steps have been taken to carry out the lethal process on a large scale. The objection even to retention of blood so strongly felt by the Jewish people do not obtain by the process, as the animals in the sleep of death are found to yield up blood just as freely as in the ordinary way, or when no anæsthetic is used.

Upon the issue of these experiments Dr. Richardson deserves the gratitude of the entire community. Looked at from whatever point, his efforts were praiseworthy, and the results constitute a triumph to science and a boon to the lower creation. If—as he eloquently concluded his lecture—Science sometimes, for the sake of man, inflicts pain on the lower creation, here she relents, and does for the lower creation what she dare not do for man.

CREDE'S METHOD OF DELIVERY OF THE PLACENTA.—Dr. W. H. Taylor, in the *Cincinnati Lancet and Clinic*, says: The vigorous controversy over "Crede's method," which has recently involved so many obstetricians, has led Crede to restate in detail the manipulation he advises. As many American practitioners habitually adopt what they believe is his practice, I think it will be of interest to know exactly what that method is, I therefore have translated his own description, giving the italics as found in the original, in the *Archiv. für Gynakologie*, xxiii, 2, 213:

. . . . "The natural detachment of the placenta occurs within a few minutes after the birth of the child, and is recognized by a discharge of blood and by marked diminution of the size of the uterus, which may now be felt as a firm ball, the size of a child's head, between the umbilicus and pubes. As soon as any after-pains have occured the midwife grasps the entire uterus through the abdominal walls with both hands and presses it toward the concavity of the sacrum, she repeats this *several times*, if necessary, *but only during a pain*, until the placenta is found at the vulva or is entirely expelled. If, from imperfect contraction of the uterus, or from tenderness of the abdominal walls, sufficient pressure to expel the placenta can not be made, the attendant, guided by the umbilical cord, feels carefully in the vagina for the placenta; if a portion is felt, then, with one hand, *gentle* traction is made on the umbilical cord, while with the other pressure is made over the uterus. If the point of insertion of the cord in the placenta can not be reached, or if on *gentle* traction of the cord resistance is felt, no further effort to deliver the placenta in this way may be made until after *several uterine contractions* have occurred, which may be increased by *gentle* rubbing and pressure. If the placenta is found low in the vagina, and readily reached by the finger, then the attendant shall pass the index and middle fingers as far upon the placenta as possible and press it gently downward and backward, while with the left hand the cord is made tense. When the placenta appears at the vulva the attendant shall grasp it with the fingers of one hand, and draw it gently upward and slowly turn it upon itself several times in order that the membranes may form a cord and not be torn away. When delivered the entire after-birth and any coagula are removed under the flexed leg of the woman and placed in an empty basin.

"*All strong traction* on the umbilical cord, or attempts to extract the placenta when high up by introducing a part or the whole hand, or to aid the efforts at extraction by straining, coughing, blowing in the hands, etc., are *very dangerous* and therefore are *forbidden*."

HIP-JOINT AMPUTATION. — DAVY'S LEVER.—The following important cases under thecare of Mr. Haward, of St. George's Hospital, London, are reported in the *Lancet* for January 3, 1885:

John D——, aged twenty-four, received in May last a blow on the right buttock from the buffer of

a locomotive. When admitted soon afterwards into St. George's Hospital, the buttock presented near its most prominent part a contused and lacerated wound large enough to admit a finger. Out of the wound dark blood oozed very freely. The soft parts were very extensively undermined, and beneath them was a large and increasing collection of blood. This blood collection did not pulsate and no bruit was audible. A pad was firmly bandaged over the buttock for three hours. In this interval the collection of blood had greatly increased, and when the pad was removed large quantities escaped. Ether was then administered and the right iliac artery compressed with Davy's lever. When once introduced far enough, this instrument acted perfectly. Mr. Haward enlarged the wound to a length of some six inches. The gluteal muscles were found to be torn across, and beneath them existed a large cavity full of blood. This was quickly turned out, bringing into view the sciatic notch and the open mouth of the gluteal artery. This and a great many other muscular vessels were secured with catgut ligatures. No blood was lost during the operation and the man's recovery was uninterrupted.

The case shows well the value of the lever, and in connection with this subject of compression of the large vessels of the abdomen it seems well to mention a case of amputation at the hip-joint for sarcomatous disease, which also occurred in Mr. Haward's practice. Here the abdominal aorta was very effectually controlled by a contrivance more or less like that suggested by Sir Joseph Lister. The blunted apex of a pyramidal piece of wood was fixed over the abdominal aorta by an elastic bandage. The apex of the pyramid was about one inch square and covered with felt. The base measured about three inches square and presented instead of a plane surface a broad and shallow groove. The elastic bandage passed round the pelvis and along this groove. When fixed it was placed in the charge of an assistant, who, grasping the wood with both hands, could very easily and nicely direct and regulate the pressure. This contrivance caused no dyspnœa and completely checked all bleeding.

THE ENGLISH CHOLERA COMMISSION.—Drs. Klein and Gibbes have sent the following report to the Surgeon-General and Sanitary Commissioner of the Government of India. Dated Calcutta. Nov. 27th, 1884.—*(Lancet, Jan. 3.)*

We have the honor to report that the investigations which we have hitherto carried on in Bombay and Calcutta have yielded the following results:

1. The statement of Koch that "comma bacilli" are present only in the intestines of persons suffering from or dead of cholera is not in accordance with the facts, since "comma bacilli" occur also in other diseases of the intestines—e. g., epidemic diarrhœa, dysentery, and intestinal catarrh associated with phthisis.

2. The "comma bacilli" in acute typical cases of cholera are by no means present in such numbers and with such frequency as to justify Koch's statement that "the ileum contains almost a pure cultivation of comma bacilli"

3. The "comma bacilli" are not present in the tissue of the intestines or elsewhere.

4. The "comma bacilli" in artificial cultivations, carried out by one of us (E. K.), do not behave in any way differently from other putrefactive organjsms.

5. Mucous flakes of the ileum, taken out soon after death from typical acute cholera, contain numerous mucous corpuscles, many of them filled with peculiar minute straight bacilli. The same bacilli occur also outside the mucous copuscles. They are never missed even when the "comma bacilli" are.

6. These small bacilli have been cultivated by one of us (E. K.), and they do not behave differently from putrefactive organisms. They are not present in the tissues of the intestine or any other tissue.

7. No bacteria of any kind, and no organisms of known form and character, occur in the blood or any other tissue.

8. A good many experiments have been carried out by one of us (E. K.), with the following results: *(a)* Mice, rats, cats, and monkeys were fed with rice-water stools, with vomit, with mucous flakes of the ileum, fresh and after having been kept for twenty-four to forty-eight hours. The animals remained normal. *(b)* Inoculations with recent and old cultivations of "comma bacilli" and the small straight bacilli, as well as with mucous flakes, were made into the subcutaneous tissue, into the peritoneal cavity, into the jugular vein, and into the cavity of the small and large intestine of rabbits, cats, and monkeys; but the animal remained perfectly well and normal.

9. The material which we have had hitherto at our disposal has been very good and abundant, and, as far as the microscopic work goes, we do not think we shall require any more material. We therefore propose concluding our inquiry by the beginning of December, and hope soon after to return to England.

PATHOLOGY OF CYSTITIS.—According to M. Hache (*Revue de Chir.*, No. 4, 1884) lesions of the bladder and irritation applied directly to its wall and mucous membrane do not constitute a necessary and sufficient cause of cystitis, except in case of vesical tuberculosis, or of the presence of a rough and irregular shaped foreign body. The causes capable by themselves of constantly determining inflammation of the bladder are very rare. Beyond tubercular cystitis, and other forms of cystitis due to some general morbid condition—as.

for instance, those of rheumatic, gouty, and infective nature, which are not of frequent occurrence —there cannot be included in the above category scarcely any save severe accidental or surgical traumatisms of the bladder, and too sudden and complete evacuation of this organ after over-distension. Gonorrhœal urethritis does not often give rise to cystitis, except under the influence of some occasional cause or in a predisposed subject. Most of the predisposing causes act quite simply by determining a more or less persistent congestion of the bladder; others have a more or less obscure mode of action, although their influence is very decided. Chief amongst these predisposing causes are the tubercular, rheumatic, and gouty diatheses. These predisposing causes may sometimes become exciting causes by increase, extension, or repetition of their action, or through association with that of other causes of the same group. These latter causes are congestion and slight inflammation of neighboring organs, especially in the female; tumors, calculi, and foreign bodies in the bladder; incomplete retention of urine, with or without distension; habitual resistance to the needs of micturating, and all the causes of dysuria and functional over-activity of the bladder; stricture and foreign bodies in the uretha, hypertrophy of the prostate, etc. Finally, the part of exciting cause is more especially played by sudden and complete retention, by cold, by catheterism or exploration of the bladder. The latter cause can act only on a bladder predisposed by the presence of a tumor or calculus; the other two causes are more active, and may even by themselves suffice to excite an attack of cystitis. M. Hatche's study of the pathogeny of cystitis has led him to insist on the importance of congestion and diathetic influences, especially the tubercular diathesis, and on the relatively limited part played by lesions of the urethra and prostate.—*London Med. Record.*

TREATMENT OF ABSCESS OF THE LIVER.—A few years ago M. Jules Rochard reported to the Académie de Médecine a method of healing abscesses of the liver by large and direct opening, combined with the Listerian antiseptic method. This operation consists, when the abscess is only suspected, without being diagnosticated, in using tne needle of an aspirator. Then if pus be found, the needle is used as a director along which a bistoury is carried, and the abscess is opened. The cavity is then injected with antiseptic solutions, and drained. About the same time, Surgeon-Major Oberlin, of the French Army, had occasion to treat several cases of abscess of the liver. He gives the history of three cases. The first case was aspirated with Potain's aspirator, a large amount of chocolate-colored pus drawn off, and the patient recovered.

The second case was that of a woman, thirty-six years of age, about ℥xviij of chocolate-colored pus were drawn off with Potain's aspirator. The patient then had an attack of intermittent fever, and the abscess partially refilled. A little more than ℥vj of pus were removed. About six weeks afterwards a third aspiration removed about ℥viij of pus. The fever continued, however, the patient got no better, and the abscess refilled. One week after the third aspiration the abscess was opened with a large trocar, the pus removed, and a caoutchouc tube introduced. A 1 to 40 solution of carbolic acid was then thrown into the cavity, and a Lister dressing applied after the injection had ceased to return clouded. The dressings were repeated daily for five days, when the first tube was replaced by a short one. The wound was completely cicatrized in a month.

M. Oberlin believes that in using the aspirator it is well to make several punctures at intervals. He also states, what is not new, but worthy of further attention, that abscesses of the convexity of the liver cause pain in the right shoulder; but this is absent in cases of abscess of the left lobe or base. —*Archive. de Méd. et Pharm. Mil.*, Oct. 1, 1884.

VOLUMINOUS ENEMATA OF NITRATE OF SILVER IN CHRONIC DYSENTERY.—Dr. Stephen Mackenzie read a paper on this subject before the Clinical Society of London *(Med. Times)*. The mode of procedure he adopted was as follows: The quantity of nitrate of silver to be used was dissolved in three pints of tepid water in a Leiter's irrigating funnel, which was connected by India-rubber tubing with an œsophageal tube with lateral openings. The patient was brought to the edge of the bed and made to lie on his left side, with his hips well raised by a hard pillow. The terminal tube, well oiled, was passed about eight or ten inches into the rectum, and the fluid allowed to force its way into the bowel by gravitation. The injection rarely caused much pain, and often none. It usually promptly returned, but when long retained it was advisable to inject chloride of sodium, to prevent absorption of the silver salt. Various strengths had been used, from thirty to ninety grains to three pints of water, but usually one drachm of nitrate of silver was employed. The treatment was based on the view that, whatever the nature of dysentery, whether constitutional or local, in the first instance, the later effects were due to inflammation or ulceration of the colon, which was most effectually treated, as similar conditions elsewhere, by topical measures. Sometimes one, sometimes two injections were required, and in some cases numerous injections were necessary; but in all cases thus treated, many of which had been unsuccessfully treated in other ways previously, the disease had been cured. The cases narrated were: 1. In which the disease had lasted several years on and off; two injections were used and the case was cured in six weeks.

2. Second attack, duration uncertain; four injections used; cured in five weeks. 3. Duration two months; two injections used; cured in three and a half weeks. 4. Duration five years; one injection used; cured in three weeks. 5. Duration eighteen months; two injections used; cured of dysenteric symptoms, but remaining under treatment for diabetes. 6. Duration fourteen months; one injection used; cured in seven weeks.

Dr. Carrington said that this treatment had been tried in the hospital at Greenwich without any remarkable effect, but the injections had not been so voluminous as those used by Dr. Mackenzie, which might, perhaps, explain the fact. The colon was usually capable of holding six pints of fluid, and the three pints used in some of the cases might possibly have failed to reach the affected parts.

REMOVAL OF GALL STONES.—The Dublin *Medical Press and Circular* of October 1, 1884, says:—The current number of the *Independence Belge* mentions a surgical operation which has just been performed in Brussels by Dr. Langenbusch of Berlin, who must not, however be confounded with his eminent fellow-citizen Langenbeck. The subject of this daring and successful proceeding was M. Eugene Anspach, the Deputy Governor of the National Bank of Belgium, who has been for many years suffering from a collection of gall stones, which have kept him in a state of aggravated suffering *(doleur atroche)* and have latterly defied all measures of relief. M. Langenbusch, summoned specially from Berlin, proposed to lay open the gall bladder, with antiseptic precautions, admitting, however, that he had only performed this operation four times, and that but one of these cases had recovered. M. Anspach's family and friends were much dismayed at this announcement, and begged that the operation should not be performed. M. Anspach was firm, and reflecting that without it he would not live long, and that in the meantime his life would be worse than death, decided on the operation. Even in this supreme moment the banking mind asserted itself, and M. Anspach remarked "after all, one in four is 25 per cent., and that is a fine dividend." "You have had one recovery already, doctor," he remarked, "and I will be the second," an element of confidence which no doubt had something to say in the result. The operation was performed on the 9th September, and 125 calculi were extracted from the gall bladder. M. Anspach suffered a good deal after the proceedings, but is now out of danger and in complete comfort. We trust he will long live to enjoy the reward of his own pluck and the skill of his surgeon. It is a curious circumstance that this operation has to a certain extent been anticipated here. The late Sir Timothy O'Brien suffered from gall stones, and the late Sir Dominic Corrigan worked down into the gall bladder by means of a potash issue, and removed them. Sir T. O'Brien's recovery was complete.

TREATMENT OF CHRONIC HYDROCEPHALUS BY TAPPING.—Dr. J. G, Palmer M.D., of Oakbowery, Ala. reports in the *N. Y. Med. Record* a case of successful treatment of congenital hydrocephalus. The patient was a negro baby, seven months old. He was called to see the child in July last. He diagnosed the case as one of congenital hydrocephalus, and told the parents that the only hope for cure was in tapping. To this they would not consent. The accumulation continued until the head reached the enormous size of twenty-six inches in circumference—the bones of the head having become very thin by reason of the pressure within. There was a space of two inches between the bones. The eyes were turned up under the upper lids from pressure upon the brain. In consultation with Drs. Garison and Spratling the importance of tapping was urged and the parents consented. A small hydrocele trocar was inserted at the posterior portion of the anterior fontanelle, the head having first been shaved at the place of insertion of the trocar. The fluid flowed freely. About eight ounces were drawn off, the trocar withdrawn, and a piece of absorbent cotton placed over the place of puncture, and held in place by a piece of adhesive plaster. The bones of the head were pressed into position, and held in place by a tightly fitting bandage. Next day bandage, plaster and cotton were removed, and more fluid was allowed to drain off, though much had done so during the night by the plaster coming off and the cotton being moved out of position. The fluid was allowed to drain off at intervals until all was removed. The child was then put upon iodide of potash, which was kept up for several weeks, The eyes soon regained their normal position. The child nursed well and fattened rapidly. There were some febrile symptoms for several days after the operation, but they soon subsided. The head is yet big from the large size of the bones, as they were very thin. The bones seem to be rapidly uniting, and the child is still fattening and growing.

INCONTINENCE OF URINE IN CHILDREN.—In his recent work on diseases of children, Dr. Eustace Smith gives the following:

Of medicines which diminish irritability, belladonna takes the first place; but it is important to be aware that this remedy, to be effectual, must be given in full doses. Children have a very remarkable tolerence for belladonna, and will often take it in surprising quantities before any of the physiological effects of the drug can be produced. In obstinate cases of enuresis the medicine should be pushed so as to produce dilatation of the pupils with slight dryness of the throat. In children of four or five years of age, it is best to begin

with twenty-five or thirty drops of the tincture of belladonna, given three times in the day, and to increase the dose by five drops every second or third day, of course watching the effect. Ergot is another remedy which is often very successful. For a child of the same age twenty drops of the fluid extract may be given several times in the day.

Bromide of potassium, benzoic acid (dose, five to ten grains) and benzoate of ammonia, digitalis, borax, cantharides, camphor, and chloral have all been recommended as specifics in this complaint. Sometimes a combination of several drugs seems to be more effectual than one given alone. I have lately cured a little girl, aged four years, who had resisted all other treatment, with the following draught given three times in the day:

℞ Tinct. Belladon.....ʒ j,
Potass. brom.....grs. x,
Infus. digitalis.....ʒ ij,
Aquam ad.....ʒ ss. M.
Ft. haustus.

When the incontinence continues in the day as well as at night, strychnia should be combined with the sedative so as to give tone to the feeble sphincter. In these cases, too, cauterization of the neck of the bladder, with a strong solution of the nitrate of silver (℈ j..ʒ j. to the ounce of water), has been found successful.

APPARATUS FOR CHRONIC JOINT DISEASE.—BARWELL—Mr. B. in a clinical lecture now gives the preference over Taylor's, Sayre's, and Thomas', to the following apparatus for chronic joint diseases, the apparatus being modified for different joints. The method is one to which his attention was called by Dr. Von Wahl, Dorpat, but invented by Dr. Dumbrowski of that University. The knee-joint is taken as an example. To the knee above and below the joint poroplastic felt or leather is moulded by the hand or by bandage; while these are hardening the sound limb is placed with its posterior aspect on a piece of paper and a tracing is made of its inner and outer aspects. The circumference of the top of the thigh is taken in an oblique direction, *i. e.*, from the perineum to a point a little above the great trochanter. The splint-like moulds being removed, the instrument-maker bends two flat bars of steel or of iron, about three-fourths of an inch broad, to the shape of the tracings, only with a larger divergence at the knee and two to two and a half inches longer than the limb. These bars are to be rivited to the poroplastic felt or leather, which is provided with straps. The upper ends of the bars are made fast to a well padded ischio-iliac ring, provided in front with a hinge and flap. The lower ends are fastened by a pivot joint to a plate that underlies the sole. To put the appliance on, the leather or felt is to be softened, the ischio-iliac ring opened; the limb being put in, the straps are buckled and the patient left at rest until the leather or felt has hardened. A high-heeled shoe is made for the sound foot and the patient allowed to go about; at first on crutches, afterwards without them. Motion can not take place at the joint, nor can the weight of the body fall upon it. The joint is at perfect rest and can be examined.—*Lancet.*

THE TREATMENT OF GASTRODYNIA.—The following instructive case is reported by Dr. John W. Martin, in the *Medical Press.*

Miss R., æt. 30, came under my care, October 3, 1884, suffering from pain in the stomach after meals, and the consequent dread of and loss of desire for food. When seen she looked quite worn and thin; complexion sallow; lips and gums anæmic; tongue whitish and lightly furred; bowels constipated. She felt a daily-increasing sense of weakness and inability to attend to her duties. Physical examination yielded negative results as regards the condition of the various organs. The case seemed one of dyspepsia consequent upon anæmia. The uterine functions were, with the exception of paleness of the menstrual discharge, normal.

I at first ordered bismuth, soda, and tr. nux vom. mixture with chloroform water; and calomel, colocynth, hyoscyamus pills to regulate the bowels. This giving no relief, I changed to pills of reduced iron and extract of nux vomica with meals, and as a laxative a mixture of sulph. mag. and mag carb., with peppermint water. Again no relief being experienced, I placed her upon the following prescription:

℞. Sodæ bicarb., ʒ iss.
Tr. nucis vom., ♏xl.
Liq. morph., ʒj.
Sp. am. aromat., ʒ iss.
Syrupi zingib., ℥j.
Aquæ menth. pip. ad., ℥viij.
M. ʒj. to be taken four times a day.

The relief was immediate, and so far has proved permanent. Pain is now rarely felt, and only after indiscretions as to food. Relish for her meals has returned. She is now taking the reduced iron and extract of nux vomica pills with meals, and finds decided benefit from them. The bowels are regular, the tongue clean, and her complexion and general appearance much improved.

I am inclined to think the small dose of opiate was just the one thing wanting in my previous treatment, to help the lame dog over the stile.

THE TREATMENT OF RINGWORM.—Dr. Smith, F.R.C.S, London, *Brit. Med. Journal*, says:—I have been trying for some time to find out what vehicle penetrates most deeply into the hair-follicles, and think it is chloroform. Chrysophanic

acid is a very good parasiticide; and, though it is insoluble in spirit and ether, yet it is soluble in chloroform. Chloroform also dissolves the fatty matter out of the hair-follicles, and thus allows the parasiticide dissolved in it to penetrate deeply. During the last year I have used a solution of seven grains of the acid to the ounce of chloroform to all cases of recent ringworm, and believe it is the most efficient treatment I have yet tried.

The small patches should be carefully marked out by cutting the hair very closely on them, and the chloroform solution should be well pressed and dabbed into the places with a minute sponge mop for five minutes, two or three times a day, according to the amount of irritation produced. The aim of the treatment is not to produce scabs, but to get the solution to penetrate deeply. The sponge-mop should not be much larger than a big pea, and should be continually dipped into the chloroform-bottle, as the solution soon evaporates while it is pressed into the diseased spot, and leaves the yellow acid dry on the place. Great care must be taken that the solution does not run on to the forehead or into the eyes, and that the person using it does not inhale the vapor. I always give full directions about the care necessary in using such a potent remedy, and only apply it to small places of the disease. It is well for the nurse to keep her face away from the sponge, and to use the chloroform in a current of air, and not in a small room. The places should be well washed every morning with hot water and soap, to remove any sebaceous matter or crusts, and the hair should be kept closely cut on them till new hair appears, which is generally in about two or three months; but the remedy should be continued till all diseased stumps have come out.

STRICT ANTISEPTIC SURGERY.—An interesting account as to how our German colleagues follow out the antiseptic treatment in operations and the dressing of wounds is found in the *Medical Press and Circular*. Before every operation the steam spray of corrosive sublimate is worked for some time to disinfect the atmosphere of the room. The floor of the operating-room is flooded with water, so that the assistants are compelled to wear rubber boots. During the operation a continuous stream of a solution of sublimate, 1–1000, is directed on the wound. In the dressing of the wound after the edges have been united, a layer of glass wool saturated with a ten-per-cent solution of sublimate is placed over it, over this small pillows of peat dipped in sublimate solution are placed, and over all this sublimated gauze. The dressings are never removed until the wound heals or some discharge shows through the dressings. The results gained by Schede, of Hamburg, in this manner are astonishing. Out of an immense number of operations performed in 1883, among which were nine cases of resection of the hip-joint, there were only two or three cases that showed any sign whatever of suppuration.—*Louisville Med. News.*

CHARCOT'S JOINT DISEASE.—A very important discussion of this subject has recently occurred at the London Clinical Society. The names of the prominent men who participated in the debate are a sufficient assurance that the question was illuminated with the light of the best minds of the profession. The general tendency of the meeting was to consider the affection not as a distinct disease, but rather as a form of chronic rheumatic arthritis occurring in patients with locomotor ataxia. There was a disposition on the part of the surgeons present to regard the nervous theory of its production as rather an imaginative way of explaining a gross surgical condition. Professor Charcot was invited to be present at the discussion but was unable to attend.—*N. Y. Med. Journal.*

NITRO-GLYCERINE IN MITRAL LESIONS.—At the clinic, *(Col. and Clin. Record)* Prof. Bartholow gave nitro-glycerine to a patient with a mitral lesion causing pulmonic and renal congestion, albumenuria aud general œdema. He thinks it the best thing we have for congestion of the kidneys, and valuable to take work off the heart, by lowering the tension. It does not interfere with nutrition, like digitalis. One drop of a one per cent. solution, slowly increased to flushing of the face, is the dose.

OBSTINATE CONSTIPATION.—The *Col. and Clin. Record* states that a woman presented herself at the clinic complaining of constipation consequent upon atony of the lower bowel. Often she had been six weeks without a passage, and at no time during the last year had she an evacuation under two weeks. Prof. DaCosta placed her upon the following treatment:

℞	Magnes. sulph.,	℥j	
	Acid. sulph. dil.,	f℥ij	
	Ferri sulph.,	℥j	
	Aquæ,	Oij.	M.

SIG.—A wineglassful ter die.

She was also given strychninæ sulph., gr. $\frac{1}{60}$, at meal times.

PASTE FOR COMEDONES.—Dr. A. Van Harlingen recommended at the last meeting of the American Dermatological Association the following formula for a paste for the removal of comedones (acne); it was first suggested by Unna: Glycerine, 3 parts; vinegar, 2 parts; kaolin, 4 parts.

The partnership heretofore existing under the firm name of Henry C. Lea's Son and Co., Publishers, has dissolved by limitation, and the business will be continued by Charles M. Lea, Christian C. Fenger, Arthur H. Lea and H. M. Barnes, under the name of Lea Brothers & Co.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science Criticism and News.

☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, FEBRUARY, 1885.

The LANCET *has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

THE TREATMENT OF WOUNDS.

When we consider how slight a wound may cause death, the importance of the subject which heads this article becomes at once apparent. If to this be added the great frequency of wounds, we have another cogent reason for regarding the subject as one of the first importance to every surgeon. Even in this Dominion it may safely be asserted that not a minute passes but some surgeon is at work on a wound, either accidental or surgical. It cannot therefore be wondered at that much has been said and written on the treatment of wounds, or that the subject has engaged the earnest attention of the best minds in the profession all along the line of surgical progress. Since the advent of the use of antiseptics, union by first intention has to such an extent become the rule, that any surgeon valuing his reputation is expected to offer some apology in case of failure. This certainly is a wonderful advance, and implies more, in the saving of time, pain and life, than we can have any conception of. Yet there is too much reason for the belief that, outside the great centres of population, the methods by which these humane ends are reached are comparatively neglected, and that still the old method of ligature, adhesive straps, and water dressing is in vogue. True, carbolic acid is used, and more attention is paid to cleanliness; still, in the main, modern improvements do not prevail to the extent that many imagine. The chief cause of this is not far to seek. The antiseptic treatment of wounds, as practised by Lister and his followers, is too elaborate and complicated to commend itself to those who are but seldom called upon to treat any but trivial wounds, which, as a rule, do very well under a more simple treatment. This fact without doubt has been a source of discouragement, and has engendered a spirit of apathy, not to say antipathy, towards antiseptic treatment, as well as other improvements. Now, however, that Listerism in its *entirety* has been shown to be very little, if any, superior to a modification of it, so simple and inexpensive as to be within the reach and capacity of all, there can be no longer any excuse for holding to practices long since condemned by those best qualified to speak.

Comparatively few surgeons operate under the carbolic spray. Most of them deem it sufficient to observe the most scrupulous cleanliness, combined with careful disinfection of hands, instruments, etc., with carbolic acid or corrosive sublimate in solution. All wounds should be thoroughly sponged with a disinfectant before being closed. Mr. Bryant, the celebrated operator at Guys' Hospital, recommends sponging the raw surfaces with hot water, impregnated with sufficient tinc. iodine to give it the color of sherry. This is the antiseptic used by Mr. Garrard of Sheffield, and other well-known surgeons. This method is considered by many superior to the spray, since the heat has the power of sealing up the minute vessels by coagulation. This solution is also a valuable styptic in all operations where there is oozing from a great number of small vessels. The introduction of the cat-gut ligature, which is cut short and eventually absorbed, is a great advance in surgery, and should be employed wherever it can be relied upon. This is Lister's method of securing arteries. Byrant, on the other hand, uses torsion only, even in the case of large arteries. In writing to the *Lancet*, as far back as 1874, after six years' experience of twisting, he tells that in a case of amputation of the forearm where all bleeding was arrested by torsion, except the interosseous artery, which he ligatured with gut, secondary hemorrhage occurred on the sixth day; the flaps were opened, when the bleeding was seen to come from the vessel that had been tied. He adds: "This is the only case of secondary hemorrhage from a stump which has occurred to me since I began

the practice of torsion in 1868, and it is interesting to know that it came from an artery that had been ligatured, and that the ligature was carbolized gut. . . . We have now had at Guy's Hospital 200 cases of thigh, leg, arm and forearm amputations, in which all arteries have been twisted, 110 of these have been of the femoral artery, and no case of secondary hemorrhage." It is important to add that torsion still holds out at Guy's for all vessels up to the femoral. The vessel to be secured should be separated from its sheath, and "twisted till resistance is no longer felt." It is needless to add that torsion is practised by other eminent surgeons in all countries to the exclusion of the ligature.

The next important point is accurate coaptation of the edges of the wound. Without this, healing by first intention is impossible, no matter how well other details have been carried out. In amputations, especially, it is necessary to exercise deliberation in constructing the flaps, otherwise proper coaptation may be impossible. The wound being closed, it is covered with an elastic pad of absorbent cotton, which has been impregnated with some disinfectant, and secured by the light pressure of a bandage. A drainage tube should be inserted at the lowest angle, if suppuration is deemed inevitable from the nature of the case. A wound thus treated is almost certain to do well. The main points to be be careful about are: cleanliness, disinfection, arrest of hemorrhage, accurate coaptation, and, finally, a light, *dry* dressing. All surgeons insist on the wound being kept dry, for the evident reason that moisture and heat are essential elements in decomposition. A wound properly dressed should not be disturbed for four days, unless absolutely necessary. Needless and meddlesome interference only serves to retard the healing process.

The admirable results obtained by this mode of treatment, or some modification of it, have in no small degree stimulated and emboldened the surgeons of the present day, and led them to exercise a freedom with joints, the abdomen, and the different organs, never before ventured, and that, too, with the most surprising success. While it belongs to the few to go to these astounding depths and heights, it is the duty and privilege of all who use the scalpel at all to avail themselves of approved methods, even if it be but to close a wound already made or amputate a finger.

POPULAR GULLIBILITY.

It would be natural to suppose that in this age of what is called the universal spread of knowledge, the public generally would be comparatively free from the possibility of being taken in by the ignorant charlatan. Such is, however, unfortunately by no means the case. On the contrary, this very spread of knowledge, by giving rise to new and sensational theories, seems to have a peculiar tendency to mystify and mislead.

We have been lately particularly impressed with this by recent popular expositions of the so-called science of phrenology. Phrenology, every intelligent person knows very well, if it step beyond its legitimate sphere, viz., the observation of the general configuration of the skull, and attempts to dogmatize from supposed protuberances—popularly known as bumps—is simply an absurd hoax. Yet we find persons who go about the country and earn a magnificent livelihood by publicly giving utterance to the most palpable falsehoods concerning these said bumps, and actually asserting that they are able, from them, to read character. For ourselves we see no difference between such men and the common fortune-telling gypsy. Nevertheless, it is impossible to take them to task; if the public are willing to pay their fifty cents to hear how "manhood is analysed and restored;" and five dollars to hear what line of life they should adopt, and what sort of wives and husbands they should marry, we are powerless to blame those who cater to such deplorable ignorance.

Yet there is a remedy. To us, as medical men, this is of no little import. Phrenology, as taught by the class of men to whom we have alluded, is closely allied to branches of learning which come under our special protection. It is our duty to discover means by which to eradicate, or even to make impossible, the spread of these erroneous opinions. There are various ways of doing this. But we must follow the example of these persons to this extent: our exposition of these degraded sciences must be made fully as interesting as theirs. And it is quite possible to do so—indeed, in the hands of a skilful lecturer the charlatan could be held up to merciless and ludicrous criticism. We are glad to see that the press has treated this subject properly. Let us not be behindhand in doing our best to trample down scientific falsehoods of every description.

TREATMENT OF SYPHILITIC LESIONS.

Dr. Seguin published an article in the October number of the "Archives of Medicine," on the use of iodide of potassium in large doses for the relief of the later lesions of syphilis, particularly of the nervous system. He dwells at length on the authorities regarding the dosage of the iodides. Dr. Seguin states—and states correctly, too—that text-books are generally silent on the use of iodides in extremely large doses. He also claims that the practice originated in America. Dr. William H. Van Buren was the first to give potassium iodide in very large doses, and as the results of experience showed its advantage it has been used by others in the same way. Drs. William H. Draper, R. W. Taylor, W. A. Hammond, and others have taught the use of iodide of potassium in large doses for many years, but as a rule it has not been so used until within a short time All cases of syphilis do not require very heroic treatment. When there is no immediate danger, doses of from twenty to thirty grains three times a day may be given to commence with. In the meantime the effects can be watched, as a few individuals cannot tolerate large doses. In syphilitic manifestations of the nervous system, such as convulsions, hemiplegia, coma, etc., it should be given in the very largest doses at once. Dr. Seguin recommends it in such cases in doses varying from two-and-a-half to ten drachms in twenty-four hours; he gives it before meals, largely diluted. We are pleased with the forcible manner in which Dr. Seguin has drawn attention to this important matter of treating syphilis in the tertiary stage. We have had considerable experience with iodide of potassium in the treatment of syphilis, and have given large doses of the iodides, but have never pushed the remedy to the extent that Dr. Seguin advises. We have usually administered it after meals and not before, as advised by Dr. Seguin. We have never produced iodism to any extent, nor have we observed any gastro-intestinal irritation. In some cases the addition of small doses of mercury may be made with advantage in the treatment.

AN ENQUIRY COLUMN.

It may not be generally known that there is published in England a magazine called *Notes and Queries*, a very large portion of which is devoted to questions sent in letter-form from subscribers and others on literary, historical, archæological, and other subjects, which are answered in the same form by other readers.

The London *Lancet* has for many years devoted several pages of small print to notes, short comments, and answers to correspondents. This space has been well patronized, which is the best evidence we could have of its value to the profession. Medicine above all other sciences is benefited by the free communication and interchange of ideas among its votaries, and the medical press could thus greatly advance the interests and increase the sum total of knowledge amongst the large body of medical practitioners and students. Apart from the questions discussed by medical societies, and apart from the subjects treated of in papers contributed to medical journals, there are continually cropping up isolated problems which, although in reality often of vast importance, yet cannot be brought within the scope of either of the methods above mentioned. These could be laid open for the consideration and judgment of the profession at large by such a plan as we have referred to, and which it is our intention to adopt. To the student of medicine and junior practitioner it would be a great boon. The junior members of the profession are constantly meeting with difficulties which they cannot solve. Yet many of these difficulties could be tersely discussed through the press by such members of the profession as have the time and the opportunities to devote themselves to lending their aid in increasing the knowledge of medicine besides attending to their regular professional duties. Diagnosis and treatment are not the sole end of the life of a medical practitioner, and this system of notes and queries would tend to extricate many of our medical men from the monotonous groove into which too many of them have fallen.

We invite readers to send us for our March issue a few queries, worded as briefly as possible, on which we shall hope to obtain comments and answers for the succeeding number.

PROFFSSIONAL ADVERTISING.

Those of our readers who are not in the habit of perusing English papers will be startled to hear

that the supposedly immaculate British physician has betaken himself to advertising. How hath the mighty fallen! Yet so it is. In the London *Times* of December 19th an "F.R.S." sets the ball rolling by describing how "Dr. Hughes Bennett, under whose care the patient was, guided by Ferrier's experiments, skilfully interpreted the palsies and convulsive movements which the man exhibited, and deduced from them that a small tumor was lodged at one particular point in his 'dome of thought,' and was silently and relentlessly eating its way into surrounding tissues, ... Very brilliant diagnosis this." He goes on to tell in the same graphic and dramatic way how "Dr. Godlee, surgeon to University College Hospital," excised the said tumor.

This sets the whole profession agog apparently, for in a few days the editor of the *Times* is inundated with letters. Dr. "Charles Egerton Jennings, M.S., M.B., F.R.C.S., Eng.," tells how the Vivisection Act "has delayed his own experiments on two subjects, both of considerable importance as tending to save human life when in urgent peril," and proceeds to inform the public that "in 1883 he devised a plan" by which transfusion of blood could be performed without danger. "John H. Clarke, M.D.," also rushes into a criticism of "F.R.S." And so it goes on; and all this hung on the slender peg of a revival of the agitation against the obstacles to vivisection.

We on this side of the Atlantic cannot pretend to be without sin, in view of the highly sensational *items* that appear in our local papers from time to time, an even quite recently, yet if this goes much further we may feel sufficiently stainless to cast a stone or two.

MEDICAL STUDENTS ANNUAL DINNER.—The medical students of McGill Medical College, Montreal, held their annual dinner on the 4th of December. The members of the Faculty, University officials and a large number of distinguished guests were present. Delegates were also present from the medical schools of Toronto, Kingston, and Montreal. The speeches were appropriate and eloquent, the programme excellent, and the entertainment most successful.

The annual dinner of the medical students of the Kingston Medical College was held on the 11th of December, and was a most successful gathering. Representatives were present from the medical schools in Toronto and Montreal, besides a large number of graduates and friends of the college.

The second annual dinner of the students of the Medical College in Winnipeg, Man., was held on the 19th of December, and was a great success. Speech, song and sentiment were the order of the evening, and a very pleasant time was spent by all.

TREATMENT OF TUBERCULOSIS.—Our foreign exchanges have had a good deal to say recently regarding the treatment of phthisis. R. Shingleton Smith, M.D., London (*Brit. Med. Journal*), read a paper at the meeting of the International Medical Congress at Copenhagen, in which he strongly advocated the use of iodoform in tuberculosis. He commences with small doses—one to two grains every four or five hours—and gradually increases the quantity till four to six grains and even more are given.

PELLETIERINE IN TAPE WORM.—Dr. Wilfert of Cincinnati, has been experimenting with pelletierine in the treatment of tape worm, and reports the result in the *Lancet and Clinic*, Dec. 27th. This remedy is an alkaloid obtained from pomegranate. The dose is from four to fifteen grains, and should be combined with an ounce of tincture of jalap, or the latter administered a short time afterwards. The results in Dr. Wilfert's practice have been most encouraging.

GASTROTOMY FOR EXTRA-UTERINE PREGNANCY.—In the LANCET for January 3rd, 1885, will be found a report of two cases of gastrotomy for extra-uterine pregnancy by Dr. James Braithwaite, of Leeds. Both patients recovered. In each case the placenta was apparently attached to the abdominal walls, and was left to slough off and escape through the lower part of the abdominal incision. This was accomplished in about three weeks.

MALTINE LABORATORY BURNED DOWN.—The laboratory of the well known firm of Reed & Carnrick was recently completely destroyed by fire, involving a heavy loss to the owners. New buildings have been secured, and the machinery for the manufacture of maltine is being rapidly put up, so that they will soon be able to fill orders for their specialties as usual. Peptonized cod-liver oil and

milk, one of their later specialties, though not long before the profession, already occupies a prominent place among preparations of its kind. It contains 52 per cent. pure oil, and being peptonized in combination with the milk is easily assimilated. It is very palatable; the taste of the oil is well disguised, and it agrees, as a rule, with the most delicate stomach.

COCAINE IN LITHOTRITY AND RECTAL SUGERY.—An operation for rapid lithotrity was recently performed at St. Peter's Hospital, London, *(Lancet)* under muriate of cocaine, with perfect success, and entirely free from pain. The bladder was injected with half an ounce of a 4 per cent. solution of cocaine. Bettelheim, of Vienna, reports a case of enlargement of the prostate in a patient 74 years of age who complained much of rectal and vesical tenesmus. A suppository of cocoa butter containing half a grain of cocaine was introduced into the rectum at bed-time, and relief was obtained during the night and the following day. This was repeated when required and always afforded relief. This remedy is also used in the London Hospitals in the treatment of piles, fissure and fistula with excellent results.

ONTARIO MEDICAL COUNCIL.—We observe that some anonymous scribbler has written two or three letters to the Toronto press advocating the doing away with the Medical Council. It is not our custom to notice the effusions of anonymous contributors, and we shall not depart from a well established rule in this case, further than to say that we trust no member of the profession in Ontario will allow himself to be influenced by such erratic nonsense as appeared over the signature of M.C P.S.O. The profession of Ontario will be very foolish if it ever allow the management of its own affairs to be handed over to the senate of any University however powerful or popular it may be for the time being. There is no prospect of more than a *quasi* or partial federation of the colleges at best, and even if it were an accomplished fact in the fullest sense, that is no reason why the profession of Ontario should, of its own action, yield up any of its privileges or delegate its most important functions to a non-professional body. We will never consent to that.

NEW REMEDY FOR CANCER.—Another new remedy for cancer has been recently investigated. It is a Brazilian plant named *alvelos* belonging to the euphorbiacæ. It has been used in the hospitals in Brazil, it is said, with success in several cases. From the reports which so far have reached us, however, it appears to be of value only in the treatment of epithelioma.

MONTREAL CARNIVAL.—One of the most noticeable features of the Montreal Winter Carnival is the magnificent special "Carnival Numbers," issued by Montreal publishers. Messrs. Dougall & Son, of the Montreal *Witness*, have issued an excellent number, teeming with illustrations, and having a gigantic four-page picture—"Storming of the Ice Castle by Night"—designed by Mr. R. Harris, A.R.C.A. Besides this there are full page pictures by Messrs. Bird, Raphael, Walker, and other Canadian artists, and the number also contains the Carnival Poem, appropriately illustrated, for which a prize of $100 has been paid, and a special Supplement representing the various athletic clubs and their leading men. The letterpress pages have been tastefully prepared, and contain a very large number of engravings, representing various phases of our Canadian winter sports. The price is ten cents per copy, postpaid.

EXCISION OF A TUMOR OF THE BRAIN.—The sequel of the case of excision of brain tumor reported in our last number has unfortunately terminated in the death of the patient. Hernia cerebri supervened, but the cause of death was meningitis which extended to the base of the brain. The brain was otherwise practically normal.

APPOINTMENTS.—Dr. H. V. Ogden (McGill), has been appointed Prof. of Materia Medica in the Milwaukee Medical College, Wisconsin.

The following gentlemen have been appointed commissioners under the Liquor License Act: Drs. J. S. Sprague, of Stirling, and J. S. Loomis, of Madoc, Ont., for the Co. Hastings; Dr. A. Rockwell, for Hastings, W., and Dr. A. McLean, for Lambton, W.,

ARSENIC IN TUBERCULOUS DISEASE OF JOINTS.—Arsenic in the form of Fowler's solution is highly recommended for tuberculous disease of the joints, especially when the disease is of long standing and the patient debilitated by suppuration. It is given in combination with cod-liver oil.

REMOVAL.—S. F. Wilson, M. A., M. D., C. M. (McGill), has removed from Berwick to Sussex, where he has become associated in partnership with Hon. Dr. Vail. Dr. Wilson leaves a host of friends at Berwick to regret his departure from their midst.

Dr. Darling, Prof. of Anatomy in the University of New York, died on the 25th of December, '84, at the advanced age of 82 years.

The death of Dr. Mahomed, at the early age of 35 years, is announced in our British exchanges.

Prof. Jaeger, of Vienna, the celebrated oculist died recently at the age of 77 years.

We regret to notice the sudden death of Mrs. G. O'Reilly, relict of the late Dr. O'Reilly, Hamilton. Three of her sons are members of the medical profession, Dr. Charles O'Reilly, Medical Supt. Toronto General Hospital, Dr. Gerald O'Reilly, Fergus, Ont., and Dr. Ed. O'Reilly, *S.S. Peruvian.*

BROMIDE OF ARSENIC IN PIMPLES.—It is stated on the authority of Dr. Piffard of New York, that bromide of arsenic is a cure for pimples. The dose is one to two minims of a one per cent. solution three times a day.

BRANTFORD HOSPITAL.—The "Stratford" Hospital, Brantford, will be formally opened by the Lieut.-Governor on the 10th inst. The Governors for 1885 are J. H. Stratford, Dr. Digby, Mayor Scarfe, Dr. Harris and Ald. Heyd.

BRITISH DIPLOMAS.—It affords us much pleasure to state that Dr. R. J. B. Howard, son of Dr. R. P. Howard, of Montreal, has recently obtained the F.R.C.S., Eng.

CHANGE OF ADDRESS.—The manufacturers of the Tucker Truss have removed from 123 Church Street to 274 Yonge, E. A. Smith's late address. See advt.

The Queen has appointed Prescott Hewitt, Bart., F.R.S., Sergeant-Surgeon in ordinary in place of the late Mr. Hawkins.

Dr. Sullivan, of Kingston, has been made a life senator of the Dominion of Canada. We congratulate our worthy confrère upon his appointment.

CORONER.—Dr. J. O. McGregor, of Waterdown, has been appointed Coroner for the Co. Wentworth.

Books and Pamphlets.

THE POPULAR SCIENCE MONTHLY FOR JANUARY, 1885. New York: D. Appleton & Company. Fifty cents a number, $5 a year.

The January number of "The Popular Science Monthly" teems with thoughtful and practical articles. The first is "A Glance at the Jury System," by C. H. Stephens, who makes the defects of the system very evident, and shows that it was not established as a bulwark of popular liberty. In "Agnostic Metaphysics," by Frederic Harrison, "Last Words about Agnosticism," by Herbert Spencer, the religious discussion by these able thinkers may be said to be closed, for Mr. Spencer states that he shall say no more. "Influences determining Sex" by Prof. W. K. Brooks gives the results of a curious scientific research. The story of Tyndal's student-life, told by himself, under the title "My Schools and Schoomasters," will be eagerly read. "Studying Germany," by Horace M. Kennedy, coutains valuable information for American students. J. H. Pooley, M.D., describes that curious affection, "Bloody Sweat"; W. M. Williams writes on "Condiments" and "The Cookery of Wine"; and "Protective Mimicry in Marine Life," by Dr. W. Breitenbach; "The Advantages of Limited Museums," O. W. Collet; "The Architecture of Town-Houses," by R. W. Edis F.S.A.; and "Mountain Observatories," are all valuable articles. The subject of the portrait and sketch is that eminent chemist Sir Henry Roscoe.

DISEASES OF WOMEN, by H. MacNaughton Jones, M. D., F. R. C. S. I. & E. New York: W. Wood & Co. Toronto: Williamson & Co.

Those who desire to obtain, at a minimum cost of time and money, a better acquaintance than the present educational facilities of this country present to the aspirants for gynæcological celebrity, will find in this work of Dr. Jones, conveyed in clear and plain terms, if not all that the modern infinitude of female diseases may seem to demand, yet perhaps sufficient to serve their more pressing needs, not only in the line of positive instruction, but also in that which is not less useful to the ambitious neophite,—salutary admonition. To the admirers of the gynæcological *armamentarium* the 180 well executed plates contained in the book, must give it an attractive prestige, whilst to the

budding specialist they may prove profitably deterrent, until his finances may enable him to procure a more complete gynæcological equipment.

HENKE'S ATLAS OF SURGICAL ANATOMY—A SERIES OF PLATES ILLUSTRATING THE APPLICATION OF ANATOMY TO MEDICINE AND SURGERY—Translated by H. A. Rochester, M.D., Lecturer on Pathological Anatomy, Miami Medical College, Cincinnati: A. E. Welde & Co., 1884.

This fine volume reflects credit on the enterprise of the publishers. It contains eighty-one plates, which have been executed with rare skill. These plates may be regarded as a supplement to any text-book of anatomy or any atlas of descriptive anatomy, filling the niche which they have left vacant. They will be valuable to students and practitioners. To the former as a means of fixing in their minds the lessons learned in dissection: to the latter accurate pictures are presented of the connections and relations of the viscera, as well as of the appearance of parts, just as they are exposed by the surgeon during operations. The price at which it is offered is very low ($10). This work ought to command a large sale.

ADAMS' HISTORICAL CHART; with Maps of the World's Great Empires. New York:—Colby & Co., 5 Union Square.

The object of Adams' Chart is to picture history, and to so arrange and tabulate the subjects of history that men, events, and nations, may be located in time by being seen in their positions on the charts as the school atlas locates places. To accomplish this, the chart is divided by perpendicular lines into the 59 centuries and their decades, and colored lines passing from left to right represent different nations, change of rulership being indicated by change of color. The rise, progress, and fall of nations are prominent features in the chart. The plan is so simple that children can readily understand it, and so comprehensive that it is in itself an historical cyclopædia for the mature scholar. An explanatory key accompanies the chart. It is published in three forms, on rollers, portfolio, and book form. Price from $10 to $15.

THE MONTREAL DAILY STAR.—Carnival number, 1885. Montreal: Graham & Co. Price, 15cts.

This is a highly creditable production, and is in great demand. It contains besides choice reading matter, beautiful colored plates of the various carnival scenes both real and imaginary; the allegorical representation of the carnival; the skating carnival representing the various costumes worn; the "Tandem Club" turn out; the ice lion, and the ice condora; representative ancient and modern houses in Montreal; tobogganing slides; the ice palace; the politicians at the carnival; storming the ice palace; snow shoe club, etc. etc. It is one of the best productions of its kind ever printed in Canada, and reflects no small credit upon the publishers.

THE LONDON MEDICAL STUDENT, AND OTHER COMICALITIES, selected and compiled by Hugo Erichsen, M.D., author of Medical Rhymes. Published by Dr. H. Erichsen, 11 Farmer St., Detroit, Mich. Price, $2.00.

This interesting compilation is admirably adapted to instruct and amuse the busy practitioner in his leisure moments, or while waiting on the sometimes slow process of nature in the lying-in room. The London Student was originally published in *Punch* half a century ago, and the authorship was variously assigned to Hood, Dickens, Thackery, Mark Lemon and Douglas Jerrold. It is a very amusing satire on medical student life in those days. A number of amusing anecdotes chiefly of a medical character complete the volume.

MANUAL OF ORGANIC MATERIA MEDICA, for the use of Students, Druggists, Pharmacists, and Physicians, by J. M. Maisch, Phar. and Prof. of Materia Mhdica in the Philadelphia College of Pharmacy. Second edition, with 240 illustrations. Philadelphia: Lea, Bros. & Co. Toronto: Williamson & Co.

The author is well known as the joint author of the *National Dispensatory*, and the work may be regarded as a companion to the Dispensatory. It is adapted for the use of students as an aid in systematic instruction, filling a position which could not be done by the larger work. The author gives in a concise form the *essential* physical, histological, and chemical characters of organic drugs. The classification, which is according to the origin of the drug, is the author's, and while he is "conscious of its imperfections believes it to be convenient and capable of practical application."

MICRO-ORGANISMS AND DISEASES, by E Klein, M. D., F.R.S., New York: McMillan & Co. Toronto: Williamson & Co.

This is a valuable little work which must prove

very useful to those who desire to acquire an introductory knowledge of the important subjects treated of in it. The work is a small octavo of 191 pages, in small but neat type. It contains no less than 108 illustrative plates, which must materially aid the reader in his study of this interesting and useful department of modern medicine.

THE BASIC PATHOLOGY AND SPECIFIC TREATMENT OF DIPHTHERIA, TYPHOID, ZYMOTIC, SEPTIC, SCORBUTIC AND PUTRESCENT DISEASES generally, by George I. Ziegler, M.D. Philadelphia, G. I. Ziegler. Toronto: Williamson & Co. Price, $2.00.

This work contains a general summary of the basic pathology and specific treatment of the above diseases from the author's point of view, viz: the pathogenic factor, ammonia engendered from within or introduced from without the economy. The work is very interesting and will well repay a careful perusal.

ELEMENTS OF PRACTICAL MEDICINE by Alfred H. Carter, M.D. New York: D. Appleton & Co. Toronto: Williamson & Co.

It is only necessary to mention in evidence of the high appreciation of this work by students preparing for final examination that within a comparatively short time a third edition has been called for. The work is compact and comprehensive, and will be useful as an aid, and convenient for reference, to students in attendance on lectures or clinics.

HOLDEN'S ANATOMY.—A Manual of Dissection of the Human Body, by Luther Holden, late President of the Royal College of Surgeons, England, etc. Fifth edition. Edited by John Langdon, Lecturer on Anatomy at St. Bartholomew's Hospital, etc. With over two hundred illustrations. Philadelphia: P. Blakiston, Son & Co. 1885. Toronto: Willing & Co.

This excellent work on practical Anatomy has many points of special merit to commend it as a manual of dissection. The descriptive part is concise and accurate, the relative situation of parts is made clear, and many valuable practical suggestions are thrown out here and there as to diseases and injuries which are liable to occur in the part under consideration. A number of new diagrams and illustrations are introduced in the present edition, and more space is given to the consideration of the anatomy of the nervous system.

THE PHYSICIAN'S POCKET DAY-BOOK, by C. Henri Leonard, M.A., M.D., Detroit, Mich., 1885.

This will be found a most admirably arranged companion to the practitioner. It differs from most of its kind in having no other matter except the daily record of business, obstetrical memoranda and miscellaneous accounts.

DRUGS AND MEDICINES OF NORTH AMERICA. A Quarterly Journal devoted to the botany, pharmacy, and therapeutics of the medical plants of this Continent. Cincinnati: J. & C. Lloyd.

We have received the first and second numbers of this interesting and practical Quarterly. The work is an entirely new venture, and has a wide field of usefulness before it.

TEXT-BOOK ON HYGIENE by Dr. George H. Rohé, Professor of Hygiene, College of Physicians and Surgeons, Baltimore. Toronto: Hart & Co.

The above work is an admirable compendium of Sanitary Science and well adapted for students.

MANUAL OF BANDAGING by C. Henri Leonard. Second Edition. Revised and Enlarged. Published by Illustrated Medical Journal Co., Detroit.

RELATION OF ANIMAL DISEASES TO THE PUBLIC HEALTH, and their Prevention, by Frank S. Billings, D.V.S. New York: D. Appleton & Co. Toronto: Hart & Co.

CONSUMPTION, its Nature, Causes, Prevention and Cure, by J. M. W. Kitchen, M.D., Assistant Physician to the Bellevue Hospital. New York: G. P. Putnam's Sons. Toronto: Hart & Co.

Births, Marriages and Deaths.

On the 23rd of December, 1874, Dr. J. W. Sparrow, of Teeterville, Ont., aged 45 years.

On the 20th December, 1884, Dr. J. McDowell, of Shawville, Que., aged 35 years.

On the 4th ult., at Port Arthur, Dr. Lorne C. Campbell, aged 35 years.

On the 13th ult., Dr. O. T. Heartwell, of Dunnville, Ont., aged 36 years.

*** *The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

THE CANADA LANCET.

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MEDICAL AND SURGICAL SCIENCE, CRITICISM AND NEWS.

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Original Communications.

A CURIOUS CASE OF MALARIAL NEURALGIA.

BY F. KRAUSS, M.D., TORONTO.

Prof. Med. Jurisprudence Woman's Med. College.

On the 16th of March, 1884, I was sent for to attend Mrs. J. N——, æt. 33, who was suffering from a severe attack of neuralgia. The patient's appearance presented all the characteristics of the malarial cachexia; she was much emaciated, and her complexion was considerably jaundiced. The history of the case is a peculiar one. For three years previous to 1881 she had resided in different malarious districts in Michigan, but enjoyed complete immunity from malarial symptoms until April in the year mentioned, when she was prostrated by an attack of intermittent fever, which continued, with more or less severity, for three months, the paroxysms being quotidian. In the fall of the same year occurred the first of a series of periodic attacks of neuralgia which have since been maintained with unvarying regularity as to time of occurrence and succession of symptoms. Previously to her illness the woman had always enjoyed perfect health, was strong, vigorous, and active. Family history good.

The characteristics of the periodical neuralgic attacks—as described by the patient and her husband—are as follows: Each attack consists of a "period" of nine days, and occurs twice in the year—in the spring, about the time the snow is disappearing; and in the early winter just before the first appearance of the snow. The paroxysms are quotidian and retarding, that on the first day setting in about 8 a.m., and each successive one about an hour later than on the preceding day. They also gradually decrease in length of duration, usually terminating, no matter at what hour they begin, at about 9 or 10 p.m. The individual paroxysms much resemble those of intermittent as to succession of events. Each is preceded by marked coldness of the extremities, especially the feet; the other symptoms of the prodromic stage are wanting. Anorexia is persistent throughout the entire period; no vomiting. Violent throbbing, referred to the back of the right orbital cavity follows, and ushers in the cold stage. The latter only differs from the same stage of intermittent in the co-existence of neuralgia. The throbbing behind the right orbit is intensified by excruciating lancinating pain in the same situation, and, in a less degree, along the course of the right supra-orbital nerve. There is also a sense of tension and pressure behind the globus, and which the patient describes as being such as might be occasioned by the presence of an abscess. The whole region about the affected eye is tender; much photophobia exists, with redness of the conjunctiva, and a copious flow of watery fluid from the eye, which the patient declares excoriates the skin of the cheek. Movements of the orbit are attended by a grating sensation. The other eye is unaffected. During this stage the patient maintains an erect sitting posture and complains of a sensation of great distension in the head. Pain in the frontal sinuses precedes, accompanies, and succeeds the cold stage; there is no præcordial oppression. The pain during each paroxysm is remittent, each access being limited to three or four minutes and rapidly followed by another, the entire stage lasting from half an hour to an hour. The hot stage now supervenes, with a cessation of the neuralgic pain and the throbbing, only a feeling of soreness and tenderness remaining. In an hour or two the pyrexia abates, and the sweating stage sets in. The patient, utterly exhausted, falls asleep, and usually sleeps until morning.

The above succession of symptoms is repeated daily—but commencing each day at a later hour—until the ninth day, when a curious phenomenon is described as invariably occurring. The upper eyelid on the affected side becomes ecchymosed, and during or after the sweating stage the patient experiences "a cracking sensation, as if something had given way," at the chief seat of pain, accompanied by immediate and sudden relief from the feeling of tension and pressure. In her own words, "an abscess seems to burst;" and she insists that a discharge of pus into the pharynx takes place.

She is now free of her enemy for the next six months, although, since the occurrence of the first neuralgic manifestations she has had frequent intercurrent attacks of true intermittent, more especially during her residence in a malarious district. In 1883 she and her husband removed to Canada —first to Hamilton and then to Toronto—and since that time she has had two attacks of true intermittent, one following the death of a favorite child. In every instance the ague was quotidian, the paroxysms beginning about 7 p.m. For a month after each neuralgic attack the patient suffers more or less from dull pain about the eye, asthenopia and tenderness of the scalp; a herpetic eruption makes its appearance about the lower lip, and desquamation of the cuticle occurs over the greater part of the surface of the body. Shortly before each neuralgic period the face assumes a deep lemon hue, but this disappears a week or two afterwards The urine is at all times high colored, and during the neuralgic periods is deeply tinged with bile. The patient can prognosticate the approach of a semi-annual attack by the occurrence of vertigo on stooping, and by the appearance of the yellow tinge over the face.

Variations of the phenomena described have been noticed on two or three occasions. Thus, in the fall of 1882, the period came on after the patient had contracted a severe cold, and lasted ten days, with the usual retarding paroxysm on each. In no other instance has the duration exceeded nine days. In the spring of 1883 the neuralgia, for the first and only time, was seated in the left eye, the right being unaffected. The phenomena which manifested themselves on previous occasions, when the right eye was the seat of pain, were exactly repeated on the left side—including those indicating the termination of the period—but with the addition of a purulent discharge from the left ear —the only occasion on which this has been observed. In the fall of 1883 there was no well-marked period; some fever and a sense of fulness in the head occurred at the usual time, but disappeared three or four days later. There were no chills whatever. The contrast between this incomplete attack and the fully developed periods, in which the chills are the marked feature, is strikingly suggestive of that between the so-called "dumb ague" and intermittent of the "shaking" type. A still more curious variation is noted further on as occurring during the period which came under my own observation. The patient has also noticed that with each recurrence of the semi-annual attack the pain in the orbital cavity appears to extend further backwards. After the first neuralgic attack, in the fall of 1881—for which the patient was treated in Michigan—onychia developed, first on the right then on the left hand, with subsequent shedding of all the nails; there was much salivation; the enamel scaled from the teeth, especially the molars and bicuspids; the teeth were loosened and later on broke off at the neck, without any appearance of caries. There was also considerable œdema of the lower extremities. The patient and her friends attribute these occurrences to the drug employed, and which, I am given to understand, was administered by "a sort of horse-doctor." It is described as a white powder, with a slightly sweetish taste. Although only half the quantity prescribed was taken (at bedtime), violent delirium set in and lasted throughout the night. The symptoms just detailed followed a few days later. The toxicologist will be inclined to regret the fact that the further services of the horse-doctor were dispensed with.

I saw the patient for the first time at 4.30 p.m. on the 16th of March, the third day of the period. On the first day, the 14th, the attack had commenced at 8 a.m., and was ushered in by the usual coldness of the extremities, and—a symptom hitherto not experienced and not since repeated—neuralgic pains down the back of the neck and along the whole length of the spine. The other symptoms as usual. The second paroxysm, on the 15th, had commenced at 9 a.m., and was less violent than its predecessor. On the 16th the paroxysm did not occur until 1 p.m., and when seen the patient was in the sweating stage. An examination revealed an anæmic murmur in the vessels of the neck, and the palpebral conjunctiva was found to be almost colourless; the face of a deep lemon tint, the skin on the affected side—the right—unnaturally dry, and the hair, especially on the right side of the head and about the right temple, turning grey; tongue slightly coated; bowels regular. In the hope of witnessing a paroxysm, and thus being able to verify the patient's statements, I postponed treatment.

March 17.—At 3 p.m. no marked paroxysm had occurred, though the patient had suffered during

the morning from feverishness and sense of fulness in the head. Both this and yesterday morning she experienced "a trickling sensation" in the upper and back part of the nose, followed by the discharge of a few drops of blood from the left nostril, which appeared to give immediate relief. This had never occurred before she said. Pulse, when seen, 80; temperature 99°. Ordered the following mixture:—

℞. Quin. Sulph .....ʒ. ij,
Acid hydrobromic.....ʒ. ss,
Extr. gelsemii fl..... ♏. xl,
Ol. caryophylli.....m. vj,
Elixir. adjuvantis (Caswell & Hazard).....ʒ. iv,
Aq. ad.....ʒ. viij.—M.

Sig.—ʒ. j. o. h. 4 tis sum.

March 18.—Saw patient at noon. Marked cinchonism; no paroxysm so far; she says the pain "is there, but the medicine is holding it back." Ordered half doses of the quinine mixture. On calling again at 4.30 p.m. found the patient in the height of a paroxysm, being the third since I had left her shortly after noon. The first of these occurred about 1 p.m., the second about 2.30, and the third at 4. This last was described as the most severe yet experienced. When seen the patient was in the cold stage; pulse 88, temperature 99⅘; unable to lie down; great photophobia; pupils dilated, although she has taken half a grain of morphia *per orem* in divided doses since one o'clock. In addition to the intense pain behind the right orbit there was a constant dull pain in the frontal sinuses and across the interorbital space. No pain whatever below the level of the floor of the orbital cavity. Action of the rectus internus and obliquus superior induced acute pain; that of the rectus externus and obliquus inferior some pain, but of a less severe character; contraction of rectus superior gave rise merely to a slight "pricking" sensation; while that of the rectus inferior was unaccompanied by pain or uneasiness. No dis-discharge of watery fluid from the eye, nor redness of the conjunctiva; no *bruit* on auscultating the temple or globus. Pressure on the right temple seemed to give relief, and was repeatedly asked for. Tremor, mainly confined to the lower jaw. For a few moments the patient appeared to be delirious; she declared her head was a balloon and was sailing out of the room, and at the same time craned her body forwards as if compelled to follow it. Also complained of neuralgic pains in the stomach. Gave morph. sulph. gr. ¼ hypodermically; pain soon after subsided and the patient fell into a dose. Half an hour later her pulse was 84, temperature 99°; pupils still dilated.

March 19.—At 4 p.m. pulse 84; temperature 99⅘. No paroxysm to-day; slight feverishness early in the afternoon. Patient complains only of slight headache and the usual symptoms of cinchonism. Vomited this morning, food and mucus, streaked with blood. No pain elicited on pressing on the teeth. Continued the quinine, gr. ijss. every four hours without the gelsemium.

March 20.—Vomited again this morning as before. A little feverishness about noon; chilly sensations with slight throbbing behind the orbit at 3 p m., but when seen at 4 p.m. this had nearly disappeared. Pulse 104; temperature 99⅘. Eruption beginning to make its appearance about lower lip. Another slight access of fever at 6 p.m. No paroxysm proper during the day.

March 21.—Patient in a state of extreme nervous depression owing to an accident to her son. At 5 p.m. pulse 96, almost imperceptible; temperature 98⅘. Complained of "pains in all her bones."

Thenceforth the patient made a rapid recovery, without the appearance of any of the phenomena described as attending the close of the period. She was put upon quinine and iron (Vallet's mass), to be continued until the usual time of the fall period should have passed. Early in May she was doing well and looking more healthy, and I have not seen her since.

BORO-GLYCERIDE IN THE TREATMENT OF SUPPURATIVE DISEASES OF THE MIDDLE EAR.*

BY A. M. ROSEBRUGH, M. D., TORONTO.

Boracic acid and glycerine, when heated, combine to form a new substance, namely, boracic glycerine or boroglyceride. The proportion is according to their atomic weights boracic acid 62 parts, and glycerine 92 parts. They are gently heated over a water bath. The boracic acid is gradually added to the glycerine, and the heat con-

* Read before the Ontario Med. Association, June, 1884.

tinued until 54 parts, or 3 molecules of water, are driven off. The boroglyceride "on cooling is an amber colored vitreous mass, which is very friable and easily broken. It is readily soluble in glycerine, but less so in hot or cold water (about 10 per cent)." "It has an acid, pungent taste, and an astringent effect when applied to mucous membranes."

This new substance or compound is an antiseptic, and if we mistake not is determined to play an important rôle in the antiseptic surgery of the near future.

I believe it was the great author of antiseptics, Prof. Lister himself, who first suggested that suppurative diseases of the middle ear should be treated antiseptically. An antiseptic dressing, in order to be effective, must insure two important conditions, namely, complete exclusion of the air, and perfect disinfection of the whole suppurating surface.

In otorrhœa, where the drum cavity communicates with the external auditory canal, by means of a perforation of the drum membrane, it would seem, at first sight, to be impossible to secure these conditions. Stimulated however by the success of antiseptics in general surgery, the profession long since commenced the use of antiseptic solutions and powders in the treatment of purulent middle ear diseases, but with only partial success. Weak solutions of carbolic acid (½ to 1 per cent.) were found to be useful for cleansing in cases of caries or necrosis of the bone, but it caused an increase in the secretion and a more swollen condition of the tympanic mucous membrane. Salicylic acid in alcoholic solution was used in chronic cases, but it was not well borne in acute cases. Iodoform, either alone or combined with other powders, as alum or oxide of zinc, has also been extensively used, but many object to it on account of the smell.

In 1879 Prof. Bezold, of Munich, commenced the use of boracic acid in the treatment both of acute and chronic cases of suppurative inflammation of the tympanic cavity, and with most encouraging results. He reported in that year 145 cases that had been treated with the boracic acid— 29 with acute, and 116 with chronic suppuration. Of the acute cases, the average duration of the discharge was only 13 days; and of the chronic cases the average duration of the treatment, until all discharges ceased, was only 19 days.

After trying saturated solutions of boracic acid, and getting no better results than were obtained from other antiseptics, he tried filling the meatus with very finely pulverised boracic acid, and with the result as just reported.

"He asserts that this method of treatment is so much more certain, and so much quicker than other methods, that he now uses it in every case of suppuration, either of the meatus or tympanum, and also after lesser operations, such as the removal of polypoid granulations, cauterization and paracentesis; he excepts, however, extensive disease of the bone and perforation of the mastoid. He does not consider that it supplants, but rather assists other methods of treatment, like the antiseptic dressing in surgery; cauterization of granulations, removal of polypi, etc., are still as necessary as ever."

"The meatus and tympanum are first cleansed carefully with a four per cent. solution of the acid, then dried thoroughly, and finely pulverized boracic acid blown in over the suppurating surface; the meatus is then closed with salicylic, carbolic or boracic cotton."

"The pulverized acid has the advantage of producing no re-action on the mucous membrane, of withdrawing the water from the membrane which keeps a saturated solution in contact with the inflamed surface, and of not forming coagulations with the secretions. In cases of otorrhea, complicated with phthisis of the lungs, the acid had no effect on the discharge." The use of the boracic aid powder, however, is attended with certain drawbacks. 1. Its application is somewhat inconvenient. 2. It retards the free exit of the discharges. 3. In some cases there is a tendency for the powder "to cake," which renders the thorough removal difficult. 4. It fails to completely remove the odor.

Boroglyceride is free from these objections. It removes the odor almost immediately, and is so easily applied, that in some cases the application may be entrusted to the patient. With its use I have also succeeded in causing granulation tissue to disappear without resorting to the use of chromic acid or the other caustics. It is used as follows: The ear is carefully syringed with a warm, almost hot, saturated solution of boracic acid. Politzer's air bag, or the eustachian catheter is used to force the discharge from the middle ear through the perforation into the external auditory canal. The syringe is again used, and the fundus of the meatus dried with borated cotton, attached to the end of a probe.

The ear mirror is now used, and, if necessary, the cotton used again and again until all the discharges are thoroughly removed. The head is bent to the opposite side, and the upturned ear is half filled with the warm solution of boroglyceride. While the head is in this position air is forced through the eustachian tube, middle ear and perforation, and through the column of medicated fluid. In addition to this the tragus is pressed backwards and inwards, so as to compress the air over the fluid. Both these procedures favor the passage of the boroglyceride into the middle ear. If the patient is unable to force the air through the eustachian tube—the catheter or the air douche is used. A plug of absorbent cotton, soaked in vaseline is used to prevent the boroglyceride from escaping. The patient is seen two or three times a week, and in the meantime the ear is to be syringed with the boracic acid solution, and the boroglyceride applied night and morning at home. The boroglyceride is used in solutions of glycerine varying in strength from 10 to 100 per cent. according to the case. Dr. R. C. Brandeis, of New York, who has been using this remedy for the last two years, commences the treatment with the more concentrated solutions, and diminishes the strength as the mucous membrane assumes a healthier condition, and as the discharge diminishes.

"This remedy, he states, has enabled him to discharge patients as cured in from three to four weeks, who, he is sure, under the old methods, would have been under treatment as many months.

With a view of making the history of boroglyceride more complete, I may add, that in March, 1882, Prof. Barff read a paper before the London Society of Arts, "On a New Antiseptic Compound and its Application to the Preservation of Food," etc. This paper was published in the Journal of the Society. In the *British Medical Journal* for April 29th, 1882, Mr. Balmanno Squire suggested that the new compound be given a trial in antiseptic surgery. This led Dr. Brandeis to use it in aural surgery, the result of which he reports in *The Archives of Otology* for April, 1884.

CHARCOT'S JOINT DISEASE.

BY C. L. COTTON M.D. COWANSVILLE, QUE.

GENTLEMEN.—As the subject of Charcot's joint disease has recently attracted a good deal of attention, I trust a few notes of a case, which I have under my observation, may prove of some interest to this meeting:

H. G., aged 42, a native of England; engaged in the dry goods business in New York during 14 years. He has a good family history; no case of nervous disease that he can discover. He had convulsions when a child, but enjoyed generally good health until 1876 when he noticed strabismus of both eyes. He had one eye operated on in Glasgow and the second in Paris, since which time he has had no further trouble with his eyes. In looking back he can notice some failure in his gait in 1879, which was soon followed by neuralgic pains in his legs. These began quite suddenly. He can remember distinctly the place and hour when he had the first attack. He describes them as the usual pains of locomotor ataxia are described—as lightning-like pains. These have continued until the present, each attack lasting two or three days, and then an intermission of two or three weeks. He also had a cord-like feeling about his waist and a weakness in the knees.

He first came under my notice in December, 1879, when he presented very typical symptoms of locomotor ataxia. His walk was quite ataxic, could not stand with his eyes closed. Patellar reflex absent; complained severely of the feeling of girdle pains; some loss of power over the sphincters and diminished cutaneous sensibility in the legs. He continued in very much the same condition, but with a gradual failure of co-ordination until July, 1883, when one day while using a saw in such a manner that his right leg was put into a swinging motion over the edge of the box, the under surface of the thigh coming in contact with the box, he noticed immediately afterwards his knee very much swollen, and during the day the leg, foot and toes were involved in the swelling. There was a slight purple discoloration on the under surface of the thigh. My attention was called to it about ten days later; there having been no pain about it from the first, it had been looked upon as a simple sprain. I found the knee and leg as far as the ankle much swollen, the joint full of fluid and crackling on pressure. It had the appearance of a joint undergoing rapid disorganization. His present condition one year since the knee was first affected will be seen by the appearance of these photographs. The joint is enlarged; the lower end of the femur appearing to be much enlarged. There are no apparent bony outgrowths. Both bones of the leg are dislocated outwards, though they can be readily replaced, and in doing so give rise to a sound as if the ends of the bones were quite worn away. There is no fluid in the

*Read before the Canada Med. Association, August, 1884;

joint, no crackling feeling present. The veins are much enlarged over the knee. Both legs are much wasted; patellar and plantar reflexes absent; cutaneous sensation entirely absent in the feet, legs, and lower half of the trunk. He can support part of his weight on the diseased knee, but is afraid to do so; consequently he does not attempt to walk, but gets about comfortably in a wheeled chair. Appetite good. Digestion somewhat at fault, but generally fair. Sexual power lost during the last twelve months. The sphincters are weakened. At times he can control his bowels and bladder; at other times he finds it impossible to do so. Has never had gastric crises, and never felt any pain in the affected knee. Girdle pains have disappeared. In reference to the loss of sensation, it is curious to note that he has a large corn on one foot which often causes him severe pain. He complains of much numbness in his fingers.

The question of the relationship of joint affections occurring during the course of locomotor ataxia with the special lesion of the spine has been very freely discussed during the last few months, giving rise to papers at the clinical and pathological societies of London. Charcot, whose name has been associated with this disease, in his earlier observations attributed it to the anterior cornua of the spinal cord becoming involved in the diseased process. But further post mortems showed that the disease could be present without lesion of the anterior cornua being demonstrated. Dr. Buzzard is strongly inclined to the opinion that the pathological centre is to be found in the medulla oblongata and brings forward as an evidence the frequent presence of laryngeal, gastric and intestinal affections (more than 50 per cent.) associated with bone joint troubles. Sclerosis attacking the vagus centre is in short his theory. Thus far there has been no discovery of a joint centre in the nervous system, and it would seem that, with the close pathological study that has been given to "centres," if such a centre existed, the question would have been set at rest before this. Charcot depends chiefly on the clinical features and pathological changes in his assumption of this being a distinct specific arthropathy. Another view of the pathology of these cases is that they are an ordinary arthritis modified by the conditions of the patient. In support of this view are the very similar joint changes noticed after injuries to nerves. Weir Mitchell, Sir Wm. Gull, Ziemssen and Charcot have all noticed cases of arthritis due to nerve lesions, and it is a question whether rheumatism has its origin in the nervous system. These lesions are usually ascribed to the inhibition of the trophic influence of certain nerves. The third view of the pathology of these joint cases is that they are ordinary rheumatic or other forms of arthritis occuring in ataxic patients independently of their nervous disease. My experience of these cases being limited to the one under discussion, I must leave the question of pathology to others who have had more experience. But I must observe the course of this case has been different from any joint affection that has come under my notice. The entire absence of pain, the rapid disorganization of the joint, with the history of a slight injury, would incline me to the view, that, firstly, there must have been a predisposition to joint affection, otherwise so slight an injury could not have caused such a serious effect; and secondly, that the trophic nerves, and I think that it is generally admitted that certain nerves have trophic influence, must have become seriously impaired in their function. If these joint affections occurring in locomotor ataxia are not specific arthropathies, and I do not think that this has yet been proved to a certainty, there is no question in my mind that they are strongly modified by the diseased nerve influence.

Correspondence.

To the Editor of the CANADA LANCET.

SIR,—I noticed in the last number of the LANCET a communication from Cornwallis, N.S., signed "A Resident Physician," directing attention to the want of medical ethics displayed by some of the fraternity in that locality. If the writer of that communication were to visit a small town, not far from the metropolis of Ontario, I could point out to him some specimens not to be excelled by the most astute thimble-riggers our friends by the sea could produce. The mode of operation adopted by the medical trickster, "down by the sea," does not indicate any great amount of shrewdness, and differs somewhat from that adopted by his species in this locality. He depends too much, I fear, upon himself and his "helpmeet." He should imitate his friend in the west, by forming a "petticoat brigade," with himself as head Beadle—

his "helpmeet" President, and his sister-in-law, should he chance to have one, as Vice, things could be worked nicely. The rank and file might be filled by the confidants of the president and vice. Thus arranged, if called to consult another physician, say in a case of confinement, he might whisper the assurance to his wife, or her sister that his timely presence had saved the friends of the patient an undertaker's bill. The president and vice could mention it cautiously, and, of course, quite casually to their lady confidants, and they, in turn, through the promptings of the president and vice, might be relied on to retail the news to the whole circle at the next afternoon "tea-party" they attended. In this way superiority and skill could be made known, and by a little indirect manœuvering the whole female community might be let into the secret—especially that part of the community likely to prove of interest to the accoucheur. The Nova Scotian, like his brother chip in this part of the Dominion, might facilitate operations to some extent by taking in a partner. The partner needn't necessarily be gorged with medical lore. He would require to be a sort of "free and easy," and be stocked with a liberal amount of conceit. His usefulness would depend very much upon his cheek; his inability to take a rebuff, and upon his ability to fix up a plausible story. In order to prove a success he would require to force himself, in a social way, into the houses of other physicians' patients, and by a little hinting and winking endeavor to create an impression that the family physician had made some remark reflecting on some of the lady members of the family. He might, at the same time, do a little puffing on his own hook—give, say, in an indifferent sort of way, a synopsis of cases "placed specially under his care," and let the public know what gratitude is due to him by suffering humanity. There are a hundred and one other ways by which our Nova Scotian friend might become enhanced in the eyes of an unsuspecting public, and should he become cornered in a treacherous and dishonorable act, he will differ very much from those of his kidney here, if he don't throw dirt and call in the assistance of his tools and minions to cover his guilt. The fact is the slipshod, artful, half positive, half negative physician, is the same kind of an animal wherever you find him, varying only in the manner he may adopt, and the facilities he may possess for performing his tricks. By all means let the Nova Scotia man have a chance, for, like his Ontario prototype, he may have only his tricks and shams, and "petticoat brigade" to depend on.

Yours, &c.,

A RESIDENT PRACTITIONER.

February 13th, 1885.

Selected Articles.

BONY UNION IN INTRACAPSULAR FRACTURE OF THE FEMORAL NECK.

Dr. John B. Roberts, of Philadelphia, read the following paper before the Philadelphia County Medical Society in November last:

Much has been said against the possibility of osseous repair occurring after intracapsular fractures of the neck of the thigh bone. It is probable that this teaching has induced more than two-thirds of the general medical profession to believe that bony union of such lesions never occurs. Careful investigation of cases and specimens by competent surgical observers has conclusively demonstrated that such belief is erroneous. Bony union does occur, though not frequently. In my opinion, moreover, its non-occurrence is to some extent due to the violent and unjustifiable manipulation to which injured hips are often subjected, by reason of the attendant's ignorant desire to demonstrate crepitus and preternatural mobility. The diagnosis can usually be made with reasonable certainty without the development of these symptoms of fracture. Therefore, it is unnecessary and improper to imperil the future usefulness of the limb merely to arrive at an absolute diagnosis. In cases of doubt it does no harm to treat the case as one of fracture, even if none exist; but violent manipulation, by tearing connecting bands of periosteum or detaching the impacted fragments, greatly reduces the probability of union.

Union *may* be bony and the function of the joint perfectly or almost perfectly restored; if not bony, the bond of union *may be* a very short, fibrous one, giving as good functional result as osseous repair. Hence, the surgeon should treat his cases as if he expected a good cure; for it is impossible to say that a given patient is one in which no attempt at union will take place. Non-union of intracapsular fracture of the hip is, it is true, often found. I have in mind now a case where the autopsy showed no attempt at even fibrous union. Let us not expect this, however, as a rule, for then we may be led to neglect proper therapeutic measures. Specimen No. 1130^{18} of the Pennsylvania Hospital Museum, taken from the patient referred to above, between eighteen and nineteen weeks after the in-

jury, is a good illustration of non-union. It was a transverse fracture at the junction of the head and neck of the bone. Specimen No 1130[80], from the same Museum, on the other hand, is here shown you; it is described in the Museum catalogue as an intracapsular fracture firmly united; and by longitudinal section shows bony union. The specimen belongs to Dr. T. G. Morton, and was removed from a patient, aged 67 years, twelve years after the accident that caused the injury. There is some evidence of impaction near the base of the neck; and it is perhaps *possible* that part of the line of fracture extended without the capsule. Of this we have no definite evidence, as the ligaments were removed in preparing the specimen. This cast of a specimen is from the Mütter Museum of the College of Physicians, and represents an impacted fracture of the femoral neck in which there was *inversion* of the leg. The patient was under the care of Dr. Conklin, of Ohio.

I have made these prefatory remarks to introduce the clinical history of a patient who has now good use of her limb subsequent to an intracapsular fracture, although treatment was abandoned shortly after the receipt of the injury. She has probably a short fibrous union; possibly a true bony one. In either event, however, the result is gratifying; and teaches that such cases should not be looked upon as necessarily hopeless in respect to union.

She is a German, 78 years old, and was admitted to my ward in St. Mary's Hospital, on August 30th, 1884, after falling from a street car. The resident surgeon believed there was no fracture at the hip; but on my visit I considered that the position of the limb and the patient's age pointed to intracapsular fracture of the neck of the femur. On taking hold of the leg and making rotation without violence I felt indistinct crepitation. At once desisting from further manipulation, I ordered permanent extension by weights and lateral support by sand bags to be the treatment. Within four days incontinence of urine, the development of a superficial bed-sore and the debilitated condition of the patient showed me that there was danger of the aged woman dying. I accordingly ordered the resident surgeon to discontinue the fracture dressing, so that the patient's buttocks and back could be kept clean and the bed-sore properly dressed; telling him that no union of the fracture was likely to occur, and that we must endeavor to save life by tonics, stimulants and food, and the prevention of further bed-sores. I gave a similar prognosis to to my Polyclinic pupils who saw the case. Ten days later, that is two-weeks from the time of injury, another incipient bed-sore was noticed on the buttocks. The hospital notes of this date say that I ordered change of posture to be frequently made, and that she sit up as soon as possible. Six days subsequently she was sitting up in a chair. I am unable to say whether she got out of bed previous to this date or not. The bladder symptoms gradually improved, she soon sat up all day, and on October 4th, five weeks after admission, it is recorded that she was walking on crutches. On October 26th she was able to walk a little *without* crutches, though she did not do so much. She continued to gain in activity until her discharge, on November 2nd.

The result was so unexpected to me, for no restraint of motion at the hip was attempted after four days, that I almost mistrusted my diagnosis, and concluded that possibly the resident surgeon's original diagnosis was correct. I had made no investigation of the condition of the limb since she began sitting up. A few days before her discharge, however, I put her in bed, and with my colleague, Dr. Keen, examined her. The leg was strongly everted, as in intracapsular fracture, immediately after the injury, and she was able to invert it only so far as to make the toes nearly vertical. She could raise the leg, however, and lay it across the other or carry it outward, and, indeed, appeared to have every motion of the joint, except full inversion, though she stated it was a little stiff when walking. She had no pain. The everted leg, therefore, made the correctness of my diagnosis an established fact. Here, then, in a woman of seventy-eight years, was obtained union and a useful limb, despite the absence of treatment. In the face of such result, treatment should always be attempted, and not abandoned unless circumstances, such as arose here, demand its discontinuance. Well directed treatment will certainly be expected to make many good cures, if no treatment will occasionally give so excellent a limb.

TREATMENT OF TUMORS.

Dr. McNaughton Jones (*Med. Press and Circular*) gives the following advice in regard to the treatment of tumors:

The larger our experience of tumors of the mammary gland becomes, the more do we see the uselessness of trusting to external applications of any kind to dissipate them. Iodide of potassium, iodide of lead, iodine, the oleates of lead and mercury, discutient lotions of chloride of ammonia with camphor, combined with compression, are at times of use in the case of small nodosities, chronic induration after inflammation, and small cystic growths, but they more frequently fail, and unless growth is otherwise arrested, the use of the knife is sooner or later called for.

Lipomatous tumors, small cystic tumors, galactocele, adenomatous nodules, may remain for years if not permanently, without growing or giving rise to any pain or even uneasiness, and all such growths cause great uneasiness in the mind of the woman, and make her apprehensive and unhappy. I am not so certain that if the rule to completely

remove any circumscribed growths from the mammæ, whether painful or otherwise were generally acted on we would not be on the safer side than to temporize with any.

Take what pains we may to assure a patient of the harmlessness of any form of breast tumor, there is a natural fear of malignant disease which tends to make her mind dwell on its presence. Also, in the instance of cystic or sarcomatous growths we know sufficient of their liability to assume a malignant nature to make us, even after years of quiescence, wish they were out of the way of harm. The surgeon is perhaps more often in doubt as to the expediency of removal of the mere growth or of the entire mammary gland. His decision must depend on the homologous or heterologous character of the growth, its size, hardness, the puckering of skin, rapidity of growth, the extent of the gland involved, and the other features which make suspicious of its malignant or sarcomatous nature. Small, circumscribed and encysted tumors of a benign type may be carefully removed, but if there are any reasonable grounds for apprehension that the disease is of a malignant nature, or likely to become so, or again, that the tumor is of large size, the best course is to amputate the breast. Encysted tumors containing fluid may be incised, and the cyst cavity treated with some stimulating fluid, as solution of iodine, carbolic acid or chloride of zinc. The nature of the fluid may be determined on previously, by drawing off a small quantity with a hypodermic syringe and examining it so as to ascertain whether it is serous, hydatid or sanguineous. Hydatid tumors must be removed. *The one safe rule in all cases of malignant growth of the breast is early amputation of the entire breast.* If the axillary glands are enlarged, these should be carefully removed at the same time and the entire axilla cleared of all suspicious nodules. The association of eczematous inflammation of the nipple and malignant disease (Paget) must not be forgotten. In a well-marked case of this nature exhibited by me at the Pathological Society of London in 1881 the woman had suffered for over two years from excoriation of the nipple, and when she was admitted to the hospital there was an area of the circumference of a crown piece, including the nipple, of eczematous ulceration (eczema rubrum). Close to the axilla was a hard mass of scirrhus, which had been ulcerated, leaving a raw surface of the vivid red coloring of malignant ulceration. I removed in this case the breast, the incision being about ten inches in length, so as to include the entire area of scirrhous infiltration near the axilla. I dissected away all the glands from the apex to the floor of the axilla. The entire dissection of the axillary structures was as clean as if the part were prepared for demonstration. Yet in one year after the operation the patient returned to the hospital with a huge fungous mass protruding from the left side of the wound. (This specimen is in the museum of the Queen's College, Cork). Only in one instance of extensive scirrhus have I operated in which there was no return of the tumor. The patient died of an attack of acute inflammation of the lungs about two years after the operation, and the breast had given her not the least uneasiness up to the time of her death. Yet it might have developed subsequently. We may decide the question of operation on these grounds:

1. The size of the tumor and the degree of infiltration of the mammary tissues; the extent to which the skin is involved, as well as the condition of the axillary glands.

2. The general health of the patient and the coexistence of malignant disease elsewhere, or of other serious constitutional disorders, as phthisis or uterine disease.

If we determine not to operate, we must palliate and relieve pain to the best of our ability by such means as compression, anodyne applications, as opium, belladonna, conium and hyoscyamus, in the form either of fomentation, ointment, or strapping, while both morphia and atropine or cocaine may be administered subcutaneously.

In conclusion, I would say in regard to any malignant or suspected malignant tumor of the breast, "Remove early, remove the entire breast, sufficient skin and all suspicious tissues and lymphatic glands.

Amputation of the breast.—Perhaps there is no operation in which the benefit of antiseptic surgery is more perfectly illustrated than in this. Union by first intention is the rule. To secure this result we should arrest hemorrhage by torsion, which if properly carried out, and care taken that the wound is not closed until all the bleeding has ceased, I find is quite efficacious, and there is little fear of any secondary hemorrhage. If ligatures are used let them be of carbolized gut. Operate with every antiseptic precaution and dress with drainage tube, and the usual antiseptic dressings. Use silver sutures or catgut to unite the margins of the wound; remove a few of these if there be any undue tension, within forty-eight hours after the operation. Dress subsequently and daily under some antiseptic spray *until the wound has united.* When the wound is healing cover it with a weak thymol or benzoated dressing and a thymol pad.

THE "UNCONTROLLABLE" VOMITING OF PREGNANCY.

A paper on the above subject by Dr. Grailly Hewitt, read before the Obsterical Society of London, is summarized in the *Medical Times* (November 22). Its conclusions are based upon two series of cases in which the condition of the body and cervix were recorded, and are as follows:—

(1) That the case in which the disease is due to some other organ than the uterus are so few in number (only one in the series of 32) that they may be almost excluded from consideration. (2) That in the large majority of cases the disease presents itself during the first half of pregnancy. (3) That the evidence points to interference with the normal expansion and growth of the gravid uterus as the condition of the production of this dangerous affection, and that this is most frequently brought about by or in connection with retention of the bulk of the uterus in the bony pelvis, in 88 per cent. the uterus being anteflexed or anteverted, and in 12 per cent. in a state of retroversion, the other conditions met with being hardness, resistance, or unusual rigidity of the os and tissues of the cervix. (4) There appear to be two factors to be considered capable of interfering with the expansion of the uterus (*a*) incarceration with flexion or version; (*b*) undue hardness, and rigidity of os and cervix. These may be conjoined in a given case. It appears to be borne out by the facts recorded that the incarceration is the more important of the two factors, as a rule at least. The facts appear to point to the occurrence of embarrassment in the expansion of the uterus very early in the pregnancy, such as might be expected to be occasioned by a previously flexed state of the uterus or by a congested indurated state of the cervix, or by the two conditions combined. As the pregnancy advances, the congestion and swelling are intensified, and the resistance to expansion thus increased. It appears probable that the particular cause of the sickness observed is the compression of the nerves situated in the tissues which are especially exposed to compression, namely, those around the cervix uteri, and especially those near the internal os. Copeman's success in the treatment of severe sickness by dilating the internal os is evidence in this direction. The importance of the flexion element has been denied, one principal objection being that sickness is not always present when the uterus is flexed. But the case is the same in the non-gravid uterus; severe sickness is not seldom due to flexion of the non-gravid uterus, while flexions are observed without sickness. Corroboration of the author's views are contained in Gehrung's recent paper. As a rule, severe sickness is limited to the first half of pregnancy, in a very few cases it persists longer; in these rare cases, the cause may be rigidity of the tissues round the internal os, persisting to a late period. As regards treatment, the first indication is to secure the normal upward movement of the fundus uteri, to relieve the incarceration of the uterus, when present, if that be possible, and to prevent its occurrence by a properly arranged method of treatment. Absolute rest in the supine position if anteversion be present or on the face or side if retroversion be present, and the use of the knee-elbow position will be required. These measures suffice in many cases. If the uterus be fixed, gentle continuous pressure must be applied internally by the fingers, or by an air-ball, and the position maintained by a suitable pessary. These measures failing, Copeman's procedure of dilating the cervix should be employed. Artificial abortion, will, it is believed, be rendered unnecessary if the less severe measures are applied early.—*Boston Med. Journal.*

NEW YORK STATE MEDICAL SOCIETY.

We give below a digest from the *N. Y. Med. Journal* of some of the papers read before the N. Y. State Medical Society on the 3rd, 4th and 5th, ult.

ACUTE PELVIC ABSCESS.—Dr. W. W. Potter, of Buffalo, read a paper with this title. The case was one of a large non-puerperal collection of fœtid pus behind the uterus, of rapid formation and accompanied with marked constitutional disturbance. The aspirator was employed when fluctation was well marked, with result of complete relief from pain, but the patient's general condition was still precarious. Various antiseptic injections having been used with little or no result, an iodoform emulsion was introduced into the abscess cavity, after the method used by Dr. Prince, of Illinois, and with the speedy occurence of improvement. The patient made a good recovery. Before the attack came on the patient had been taking cotton-root tea in large quantities by the advice of an irregular practitioner who had diagnosticated ovarian trouble; and it was a question if this had not something to do with causing the inflammation. The author referred to the frequency and importance of pelvic cellulitis, and credited Emmet with having done great service to gynæcology by emphasizing the leading part played by the affection in connection with pelvic disease. As to treatment, the author advocated the radical procedure of prompt evacuation, characterizing it as "the treatment of to-day." It was only by the vagina that pus could safely escape by spontaneous opening, but there was nothing to assure us that the abscess would not break in some other direction if there was no interference with it. The necessity of antiseptic injections into the cavity was insisted upon, and they should be given by the physician himself

Dr. Wylie, of New York, thought that the abscess must have been due either to an hæmatocele or to the access of septic material from the oviduct. He thought, too, that it was not the cellular tissue that was the seat of the collection, but the peritoneal cavity. He would prefer a trocar and canula, with subsequent dilatation, to a knife for opening such a collection. Caution should be observed in

washing out such a cavity with so strong a solution of bichloride of mercury as a 1-3,00 solution. Many pelvic abscesses, especially those of the cellular tissue, were quite as apt to point elsewhere as in the vagina, and in such, laparotomy with proper precautions, seemed to him the proper procedure, with removal of the oviducts.

Dr. Ely, of Rochester, reported a case of what might be termed "latent pelvic abscess," in a girl of sixteen years. The collection was large when attention was first directed to the abdomen. A large curved trocar was passed into the abdomen, below the umbilicus, and out through the posterior vault of the vagina, and through the canula a drainage-tube was passed. This "through-drainage" was speedily followed by recovery.

Dr. Bowditch, of Boston, related a case of pelvic abscess in a child two years of age, that had been treated like Dr. Ely's case, except that a re-accumulation of the pus led to incision and washing out of the abdominal cavity, with the most favorable result. We were still too much afraid of opening the abdomen, as, twenty years ago, we were too much afraid of opening the chest.

PEROXIDE OF HYDROGEN.—Dr. S. S. Wallian, of Bloomingdale, read a paper on this subject. It was said that it might take the place of ozone for many purposes, as a germicide, etc., while it was perfectly harmless in the form in which it was used in medicine. It acted by parting with a portion of its oxygen, which, no doubt endowed with the peculiar activity incident to the nascent state, combined directly with septic substances, and thus put a stop to the putrefactive process. The author then gave a summary of its therapeutical applications, with special reference to its use in the treatment of diphtheria. Cases of carbuncle, sloughing ulcer, and septic infection (one of each) were then alluded to as having occured in the author's practice and having been treated with the peroxide with brilliant results.

A CASE OF CANCER OE THE LIVER, characterized by a series of low temperatures, was then related in a paper by Dr. W. S. Ely, of Rochester. An uncommonly full record of temperature observations had been kept. A great number of them showed a subnormal temperature—the lowest being 91° F. There were no signs of collapse at any time, and there was no correspondence between the state of the temperature and that of the pulse, but the patient felt cold to the touch. There could be no error about the observations, as they had all been made by an experienced nurse, with a Hick's thermometer accompanied by a certificate issued from the Yale Observatory. The inferences were, that subnormal temperatures were not always so dangerous as was generally supposed, and that thermometers ought to be graduated lower than was commonly the case.

TUBAL PREGNANCY.—Dr. Squire, of Elmira, read an account of a case of tubal pregnancy in which the sac ruptured, peritonitis followed, and the fœtus was subsequently felt in Douglas's pouch, together with a large quantity of fœtid blood. The collection then burst into the rectum, with marked relief for a time, but subsequently blood-poisoning showed itself, and laparotomy was performed. The effusion was found walled in above by a false diaphragm of lymphy exudate, and the operation was abandoned. Nevertheless, the patient at once began to improve, but, some months later, she began to sink again, and died nine months after the rupture of the sac. At the autopsy, an abscess containing about twelve ounces of pus was found in the right broad ligament.

DOES QUININE ABORT PNEUMONIA?—Dr. Holt, of New York, read a paper with this title.

Dr. Bell, of Brooklyn, spoke of the malarial origin of cases of pneumonia that he had treated, particularly among children, and in the swamps of the Chickahominy.

Dr. Loomis, of New York, thought the question really was, whether the passive hyperæmia of malarial disease was identical with that of the first stage of pneumonia. Passive hyperæmia, especially in children, gave rise to physical signs that might easily lead to the case being taken for pneumonia; but he did not think such cases of engorgement would go on to the development of pneumonia, except under the influence of something else than malaria. It was impossible to stop the course of a lobar pneumonia—a disease which, he thought, was truly infectious. Was the pneumonia of to-day different from that of fifteeen or twenty years ago? In his opinion, there had been no more change in the character of pneumonia than in that of a number of other diseases, such as diphtheria and cerebro-spinal fever.

SENILE HYPERTROPHY OF THE PROSTATE was the title of a paper read by Dr. Post. The paper dealt with the subject in a systematic manner, so as scarcely to admit of a synopsis. The author showed a special syringe, of his own device, for attaching to a catheter in the procedure of washing out the bladder. It was so constructed as to admit of repair readily without its being sent to an instrument-maker, and of being attached to any ordinary-sized catheter. Stress was laid on the advantage of using large catheters in cases of prostatic disease, for the reasons that are commonly given. In the use of very flexible rubber catheters, it was sometimes useful to stiffen the distal part of the instrument by coating it with collodion. In very aggravated cases of cystitis, he had found much relief produced by applying the actual cautery to the pubic region. He was inclined to favor a resort to crushing or other operative procedures in some cases of very difficult catheterization, but the opinions of surgeons with regard to these measures were diverse.

CHOLERA AND QUARANTINE.—Dr. Van der Poel gave an extemporized *résumé* of his paper on this subject. His remarks had special reference to the question of the probable efficacy of quarantine in preventing the importation of cholera. The speaker gave an interesting description of the measures that were taken on the Red Sea route of travel, under an authority of an international sanitary board, to prevent the transportation of cholera from Calcutta and Bombay: they were almost always efficient, but occasionally the luke-warmness of the British officials thwarted them, a notable instance of which was seen in the landing of a steamer's load of steerage passengers on the western shore of the Red Sea, in order to elude observation, and the consequent spread of the disease to Egypt and thence to France. As to quarantine in the old sense of the term—absolute detention and non-intercourse—that was not what sanitarians now meant when they spoke of quarantine, but the whole system of guarding against the shipment of diseased persons, clothing, etc., when the disease broke out, so as to prevent its extension over a country. If these measures were carefully carried out, there was a great probability of our being able to stamp out the disease in case it made its appearance; but they should include detention and observation for ten days at the ports of New York, Boston, Philadelphia, Baltimore, and New Orleans. The co-operation of the Canadians could probably be counted upon, for they did not share the English view as to the uselessness of quarantine.

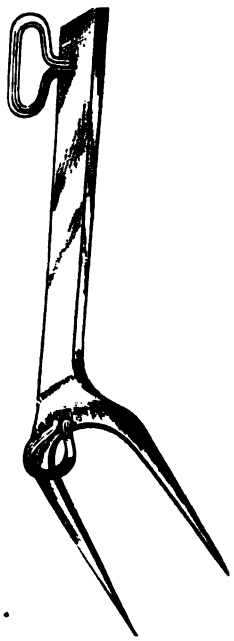
FORK FOR FRACTURE OF THE PATELLA.

Dr. L. A Stimson showed before the N. Y. Surgical Society, a fork to be used in the treatment of fracture of the patella. He had expected to show a patient upon whom he had used it with success, but the man had failed to come.

In using Malgaigne's hooks he had found it difficult to insert the hooks deeply enough to adjust the screw that connects them, and he had devised this fork as a substitute. The fork is of iron, two-pronged, the prongs bent in the flat at an angle of forty-five degrees at their junction with the shaft. The prongs are one inch long and three-quarters of an inch apart; the shaft is about three inches long. There is a small ring at the base of the prongs for the attachment of an india-rubber cord, and another at the end of the shaft for the attachment of a bandage encircling the thigh.

The instrument is used by inserting the prongs through the skin above the patella and pressing them down until they rest against the upper border of the upper fragment; the shaft lies along the median line of the front of the thigh, and is prevented from tilting or moving to either side by a roller bandage wrapped around it and the thigh. Traction downward is made by a piece of India-rubber tubing, one end of which is attached to the ring at the base of the prongs and the other made fast to the front of the skin by adhesive plaster. The introduction of the prongs can be made easily and painlessly by chilling the skin with ice and making two punctures with a knife.

In the case he had treated with this fork the fracture was transverse and the separation about an inch. The separation was readily overcome by the traction. The patient made no complaint during the five weeks the instrument was in place. The patient was kept in bed, with the limb suspended in a wire gutter, and the punctures kept dusted with iodoform; there was no inflammatory reaction about them, and only a slight discharge. The lower fragment was kept gently pressed upward by an oblique turn of a roller bandage. On the removal of the fork, five weeks after the occurrence of the fracture, the fragments were closely and firmly united, without independent mobility. As a precaution, a plaster bandage was then applied, and not removed until the end of the ninth week. The knee could then be flexed nearly to a right angle, and there was still neither independent mobility nor separation of the fragments.



ESSENTIAL EPILEPSY.—The *Phila. Med. Times* gives the following clinic by Prof. Pepper:

This little girl has been before you on one or two occasions. Let me recall to your minds the more important features in her history. She is ten years of age, born of healthy parents, with no inherited morbid tendency, and lives in a healthy

neighborhood. Up to the age of five years she was apparently healthy, but at this time it was noticed that she was "nervous" when her attention was strongly fixed. There is no history of severe sickness or other cause to account for this. Shortly after this it was noticed that the child began to have falling-spells, and these would sometimes recur as often as two or three times a day, and at no time did she go a week without an attack. In these seizures she would fall to the floor if there was no one at hand to support her, and she evidently lost consciousness for the moment, for she would assert that some one had thrown her down. There was no general convulsion, but for a few minutes there would be trembling of the hands. She did not froth at the mouth or roll the eyes, but after the attack had passed she became very red in the face.

She was brought to the hospital four months ago. At that time she was having the spells very frequently, and the mother could not trust her out of her sight. Her memory was also much impaired.

The story of this case is one of apparently essential epilepsy. No peripheral cause can be found for these attacks. The child has no heart-disease; there is no history of an injury or of a sudden shock of any kind, but gradually, without apparent cause, she at the age of five years began to have these attacks, which continued to increase in frequency until four months ago.

At that time, learning that the girl had been under the care of the family physician for some time, I concluded that the bromides had been thoroughly tried. The child was exceedingly feeble; she would drop down on the slightest exertion, and many of the falls were undoubtedly the result of muscular prostration and debility. There was also to a remarkable extent a want of mental activity. The child was listless, and her memory was rapidly failing. Concluding then that the bromides had been used, I considered it useless to push them. I thought it better to direct attention to hygiene, diet, the administration of tonic remedies, and trust to the development of the system, rather than attempt by specific remedies to coerce the manifestations of the disease.

I ordered a properly-regulated diet and the use of a simple solution of the phosphates of soda, lime and iron in an excess of dilute phosphoric acid. The child had no other treatment.

The mother reports that there has been decided improvement. The attacks do not recur so often, a week frequently intervening between the attacks. The disease is, however, far from being checked, but we are encouraged to persist in the plan of treatment adopted. In the meantime the child will be kept from school, the mother teaching her at home.

AN OLD FORM WHICH MIGHT WELL BE REVIVED, —To the kindness of Prof. Osler we owe the following copy of an indenture which was in use in the early part of the century in England, and which seems of sufficient interest to warrant publication. We commend it to the State Medical Society *(Med. Times)*.

"*This Indenture Witnesseth*, That Edward O——, of the town of Falmouth, in the county of Cornwall, by and with the consent of his Father, doth put himself Apprentice to James X., of said town of Falmouth, Surgeon, to learn his Art and with him, after the manner of an Apprentice, to serve from the 2nd day of March, eighteen hundred and Eleven, the full End and term of five years from thence next following, to be fully complete and ended.

"*During* which term the said Apprentice his Master faithfully will serve, his secrets keep, his lawful commands everywhere gladly do. He shall do no damage to his said Master, nor see to be done of others, but to his Power shall let or forthwith give warning to his Master of the same. He shall not waste the Goods of his said Master, nor lend them unlawfully to any; he shall not commit fornication or contract Matrimony within the said term. He shall not play at Cards or Dice-Tables, or any other unlawful Games whereby his said Master may have any loss, with his own goods or others during the said term, without the license of his said Master. He shall neither buy nor sell; he shall not haunt Taverns nor Play-houses, nor absent himself from his said Master's Service day or night unlawfully, but in all things as a faithful apprentice he shall behave himself towards his said Master and all during the said term.

"And the said James X., for and in consideration of the sum of forty pounds lawful money of Great Britain, one moiety of which to him in hand paid, the other moiety when half the term is complete, the said Apprentice in the Art of Surgery and Physic which he useth by the best means that he can shall teach and instruct or cause to be taught and instructed, Finding unto the said Apprentice sufficient meat, drink, lodging, and all other necessaries during the said term.

"And for the true performance of all and every the said Covenants and Agreements, either of the said Parties bindeth himself to the Other by these Presents.

"In witness whereof, the parties above named to these Indentures interchangeably have put their hands and seals this 22d day of March, and in the fifty-first year of our Sovereign Lord George III., by the Grace of God of the United Kingdom of Great Britain and Ireland King, Defender of the Faith, and in the Year of our Lord one thousand eight hundred and eleven.

"Signed, sealed, and delivered in the presence of

"I. GRIFFIN."

CHRONIC ARTICULAR DISEASE.—In the *Lancet*, Nov. 1884, p. 763, is published a lecture by Mr. Barwell, concerning the management of two principal forms of chronic articular disease; (1) that arising in the bone, and (2) that commencing in the synovial membrane. The author takes a case, in which he supposes that a certain portion of bone is enlarged, painful, and particularly sensitive to pressure; that the pain augments at night, and the limb starts violently just as the patient is falling to sleep, and the skin over the tender point of bone is red. These symptoms show that suppuration is imminent or has already commenced. This is the time for the surgeon to step in, and he should choose a point whence he could reach the bone without opening the synovial cavity; and here, pushing aside a little flap of soft parts, together with the easily detached periosteum, he may with a small trephine-head make an opening in the bone. While this is being done, he must observe what sort of fluid flows. If it be not pus, he must explore with a needle until pus is reached, or until it is certain no pus has formed. Pus, when present, should be detected and eliminated; but the treatment answers as well if pus have not already formed. After having established an opening, it should be kept open by means of a drainage-tube, so as to allow the cavity to heal with granulation from the bottom.

The author next goes on to the treatment of the sluggish form of synovial disease met with in strumous subjects, where there is a persistent tendency to the growth of flabby granulations which may ultimately undergo suppuration.

In these cases, the greatest value will be found in applying pressure to the affected part. This may be done by means of ordinary strapping, or by strapping one of the medicated plasters over the joint. The strapping should be often changed so as to make the pressure equable as well as persistent, and in many cases this is best attained by using a bandage of elastic webbing. If the swelling be large and soft, mere pressure is rarely sufficient; but the granulations must also be stimulated and this is effected by injecting among them a solution of some slight irritant. The best fluid to use is tincture of iodine, beginning with half a drachm to the ounce of distilled water, and increasing up to two drachms are generally sufficient, and this may be repeated once or twice a week. The limb must be placed in the most advantageous position, as a certain amount of stiffness is bound to follow; and great care must be taken to prevent as much as possible the limb from becoming fixed in any awkward position.—*The London Medical Record.*

A CENTRAL TUMOR CAUSES JACKSONIAN EPILEPSY.—Dr. William Osler, of the University of Pennsylvania, records in the January issue of *The American Journal of the Medical Sciences* the history of an instructive case of Jacksonian epilepsy, the main points of difference between which and true epilepsy are the slow onset, local in character, beginning in (or in mild attacks confined to) one limb or a single group of muscles; the gradual extension until the side is involved, or in severe attacks the entire body; loss of consciousness late, not early and sudden as in true epilepsy; and, lastly, the muscular contractions are clonic.

His case lasted over fourteen years, the convulsions beginning in the left hand, at first monobrachial, then extending to the leg, afterwards becoming unilateral, and finally general; at first without loss of consciousness. For the first nine years of the illness there were remarkable intermissions, lasting for six or seven months, once for an entire year. Six years after the onset, the leg got weak and stiff. For four years, the tenth, eleventh, twelfth, and thirteenth years of the illness, the seizures were frequent. During this period there were six weeks of unconsciousness, in which spasms were very frequent, from fifty to eighty in the day. Ten months prior to the final attacks there was freedom from convulsions. The intellectual faculties were unimpaired.

The case was unusual in the limitation of the lesion to the ascending frontal convolution and to its fasciculus of white matter, scarcely involving the the grey substance, which is commonly affected in cortical epilepsy. The accurate localization and the remarkable absence of tissue-changes in the immediate vicinity give the case the nature of an exact physiological experiment. With this limited lesion of the motor area there was permanent paralysis with contracture of one extremity and epileptiform convulsions. Another feature of interest in the case is the light it throws on the situation of the leg-centre. The fibrous mass was situated entirely within the anterior part of the paracentral lobule, limited in extent, confined chiefly to the medullary fibres of the superior frontal fasciculus, and only touched the grey matter in places. A point to be referred to is the absence of the paralysis of the leg for the first six years; for if the convulsions and monoplegia were caused by the same lesion, how explain the late onset of the latter? From the fibroid state of the tumor it might reasonably be inferred that it was originally larger and had shrunk; but the absence of puckering on the surface, and the way in which the margins merged with the contiguous parts, make it probable that the growth was always small, so small in fact that at one period of its development it may have caused sufficient irritation to induce the convulsions, and yet at the same time not involve the special fasciculi of white fibres to the extent of producing weakness of the leg, or monoplegia.

THE EXTERNAL USE OF CHLOROFORM IN LABOR.—The Chicago *Medical Journal and Examiner* calls attention to a peculiar method of using

chloroform in labor, which originated, it is said, with Dr. A. Svanberg, of Sweden. This doctor claims to have found that, in severe cases of labor where rigidity of the os has caused an obstacle to delivery, the external use of chloroform is very advantageous. His method consists in applying a piece of flannel soaked in a mixture of chloroform and sweet-oil (one to one or two to one) to the abdomen between the symphysis and navel. Then by light strokes over the cloth he makes sure that it is close to the skin. In severe cases (after five minutes) he pours on more of the mixture. After from five to twenty minutes Dr. Svanberg always finds that the rigidity is so much lessened that any desired manipulations, such as turning, may be performed. Five cases are reported, illustrating the efficacy of this measure.

In December, 1877, he, with three other doctors, was called to a labor, in a primipara, rachitic, with small pelvis, transverse presentation, with arm protruding. The uterus was firmly contracted around the fœtus, and it was impossible to pass the hand into it, with the view of turning. She was completely anæsthetized, and continued thus for more than an hour without result. A warm bath was given, then again chloroform, but all in vain. At last he proposed to try chloroform externally, and in about fifteen minutes he could proceed with the turning.

This practice of applying chloroform externally in order to relax the parts and permit the introduction of the hand or instruments, is especially recommended to country doctors who have no assistant to give the anæsthetic by inhalation. It is not believed that it will succeed in very severe cases. It is probable that the patient practically gets a good deal of chloroform internally by this method.—*Med. Record.*

INTRA-UTERINE MEDICATION.—Dr. Lombe Atthill read a paper on this subject before the last meeting of the British Medical Association, and gave the following conclusions:

1. Carbolic acid in the proportion of one part of spirit to two of the acid, is the safest and most generally useful of all the agents employed.

2. Carbolic acid should always be applied by means of a probe, round the point of which a layer of cotton is rolled, the cotton being carried up to the fundus at least twice on each occasion that the applications are made, which should be on every third or fourth day, till marked improvement takes place.

3. Carbolic acid should never be injected into the uterus, except when combined with iodine, in the forms known as iodized phenol.

4. In many cases, iodized phenol may with advantage be applied by means of a probe.

5. In cases in which metrorrhagia or profuse menstruation occurs, depending on an unhealthy condition of the intra-uterine mucous membrane, the cavity being dilated and the uterus enlarged, from half a drachm to a drachm of iodized phenol may be injected with great advantage.

6. In cases in which epithelioma attacks the mucous membrane of the cavity, the injection of iodized phenol promises better results than any other treatment.

7. The success likely to follow the injection of iodized phenol renders the dilatation of the uterus, the use of the curette, and the subsequent application of fuming nitric acid, less frequently necessary than has been the case hitherto.

8. The injection of iodized phenol requires to be carried out with so much care, that it should never be injected except by means of a syringe which will not contain more than one drachm

9. The use of the fuming nitric acid should be limited, as a rule, to those cases in which dilatation has been practised, and it should always be applied through a tube, inserted into the cervix uteri for the purpose of protecting the sides of that canal from the action of the acid.

10. The pain produced by the application of any medical agent to the intra-uterine cavity, does not bear any relation to the activity of that agent, but is due to one of two causes—either to hyperæsthesia, or to narrowness of the cervical canal, especially of the os internum.

MEDICAL FEES IN THE ARGENTINE REPUBLIC.—A correspondent in the *British Medical Journal* (Jan. 10, 1884) gives the following as the scale of fees in the Argentine Republic:

"The ordinary charge for a consultation at a medical man's house is said to be two dollars (about 8s.); for a visit, four dollars, say 16s.; for attendance at confinement when all goes well, about £20; but when any special care or operation is required, these fees amount up to hundreds of pounds. Accounts for medical attendance are sent in and paid without remark, which would make the hair of a paterfamilias in the 'old country' stand on end. My friend mentions the following fees as having been lately obtained by doctors who, though of good standing, are not looked on as 'stars': For extraction of ovarian tumor, £1200; amputation of arm, principal, £600; amputation of arm, two assistants, each, £400; delivery with operation, £400; attendance during typhoid fever, £200; visit by a physician for dropsy, £50; consultation fees, £20 and upwards. Much depends, of course, on the position of the patient, but there are sufficient wealthy people to make up for any small fees or gratuitous work which may have to be done among the poorer classes.

"The statements given above are confirmed by another correspondent, who states that a friend of his paid £100 for attendance at the confinment of his wife, and adds that the charges by dentists

are on a like magnificent scale, as much as £5 or £6 being paid for stopping a tooth. There, however, appears to be one important condition: before a doctor is allowed to practice in the Argentine Republic, he must pass an examination, and be licensed by the Government Medical Board; and before he can do this he must, of course, be master of the Spanish language, The population of the country is so cosmopolitan, that the more modern languages he speaks, the better will be his chances for success."

TREATMENT OF CHOLERA.—In view of the expected visit of the cholera to this country during the coming year, any contribution to medical literature, bearing upon the treatment of this disease, should receive careful and earnest consideration on a part of the medical profession. From the researches of Dr. Koch, it is now known that acids are most useful to kill the cholera microbe, and have been successfully employed by the profession in Europe.

Dr. Chas. Gatchell, of Chicago, in his "Treatment of Cholera," says: As it is known that the cholera microbe does not flourish in acid solutions, it would be well to slightly acidulate the drinking water. This may be done by adding to each glass of water half a teaspoonful of Horsford's Acid Phosphate. This will not only render the water of an acid reaction, but also render boiled water more agreeable to the taste. It may be sweetened if desired. The Acid Phosphate, taken as recommended, will also tend to invigorate the system and correct debility, thus giving increased power of resistance to disease. It is the acid of the system, a product of the gastric functions, and hence, will not create that disturbance likely to follow the use of mineral acids."

The following case is reported from Bangkok, Siam, and may be relied on as authentic: About three months ago a native was attacked with cholera. An American Missionary attended him, and administered all medicines he could, but at last the man was so far gone that they gave up all hopes of recovery, and would do no more. Relatives of the patient begging the doctor not to give him up as lost, the doctor thought of Horsford's Acid Phosphate. After the second dose the patient commenced to revive, and in six hours after, he was pronounced out of danger.

DIFFICULTY OF DIAGNOSIS BETWEEN PLEURISY AND PNEUMONIA IN CHILDREN. — Dr. J. Lewis Smith *(N. Y. Path. Society)* related the following case, and requested Dr. Northrop to give an account of the post mortem: An infant, aged eleven months, had for two months been ailing with whooping-cough. Ten days preceding the 24th of the month the bronchitis accompanying the whooping-cough became aggravated. Then, in addition to capillary bronchitis, there was an almost flat percussion sound over the right side of the chest except anteriorly, where the dulness was less marked. He supposed, therefore, that the child had pleurisy with effusion. The attending physician afterward aspirated the chest and failed to withdraw any fluid. Dr. Smith was obliged, then, to accept the probable diagnosis of pneumonia with thick fibrinous exudation over the lung. The difficulty often existed of distinguishing between pneumonia and pleurisy with effusion in children under fifteen months of age. In the present instance, as in many cases, no enlargement of the affected side could be noticed; not even bulging in the intercostal spaces.

Dr. Northrup then gave the results of the autopsy. The lungs were much more than usually compressed, and were slightly adherent anteriorly. In the pleural cavity was a pint of greenish-yellow fluid containing pus. The lung was so carnified that it scarcely rose to the surface of the water. Dr. Northrup said there were records of as many as from seventy-five to one hundred post-mortem examinations on the books of the asylum in which a mistake in diagnosis had been made between pleurisy and pneumonia in children.—*N. Y. Med. Journal.*

PERMANENT CORROSIVE SUBLIMATE SOLUTION.—Mr. Joseph Bulfin, in a note to the *Medical Times and Gazette* of November 1st, says: I have for some time been engaged in experiments and trials of various antiseptics, carbolic acid, eucalyptus, thymol, and iodoform, and since reading your article on Sir Joseph Lister's address, have made some on the following, which I think would be worth a trial. The modification which I would venture to propose is as follows: Corrosive sublimate, ℥ij; white of egg, ℥vj: Barff's boroglyceride, ℥xii; distilled water, ℥cxxv. M. The strength of the corrosive sublimate in this solution will be nearly 1 to 500. As it would be almost impossible to add the precise quantity of albumen to render the bichloride of mercury unirritating and safe, it is desirable to add an excess of albumen; but an excess of albumen on the other hand, if allowed to decompose, would be objectionable in the extreme, to obviate which I suggest the introduction of boroglyceride which, without in any way interfering with the action of albumen, whether used from blood serum or white of egg, will guard against the products of decomposition from the use of an excessive amount. The proportion of mercury used in the compound may be increased or diminished as occasion may require, and all are non-volatile. Charpie, cotton-wool, or oakum saturated in such a solution would, in my opinion, form one of the best antiseptic dressings that I have yet seen, and for the chief part of this I am indebted to Sir Joseph Lister, my only contribution being the in-

troduction of boroglyceride.—*Med. Times and Gazette*, November 1, 1884.

TENOTOMY OF THE LEVATOR PROSTATÆ IN ENLARGEMENT. — Dr. Wyman in the *Medical Age* gives the following as his conclusions in regard to the treatment of enlarged prostate :—

1. The tendon of the levator ani muscle unites with the central tendon of the perineum, and invests the prostate gland in such a manner that when the prostate is enlarged, force is brought to bear upon it during efforts to evacuate the bladder, which rotates the prostate upon the urethra and shuts off the flow of urine.

2. A section of the perineum and its deep fascia and central tendon, will remove the force expended by the levator ani muscle in producing version of the prostate, and permit the muscles of the abdomen and bladder to evacuate the urine. Such a section implies tenotomy of what some anatomists call the *levator prostatæ* muscle.

3. An operation of this character involves a breaking up of the veins and lymph spaces on the rectal and lateral aspect of the prostate, and, if the wound is made to granulate from the bottom, atrophy of the prostate will follow, so that by the time the tendon of the levator prostatæ has reunited, no further difficulty in micturition will be likely to ensue.

CHLORAL IN ALBUMINURIA. — Burduzzi (London *Med. Record*) in 1878, noticed the good effect of chloral in albuminuria, recently confirmed by Dr. Wilson in the *Brit. Med. Jour.* His case in 1878 was that of a lady, suffering from insomnia in the last months of pregnancy, with dyspnœa, from general œdema of the legs and hands, and with highly albuminous urine, in which he ordered 2 grammes of chloral to be taken in two doses every evening. This treatment was continued for about twenty days with very good effects ; sound restorative sleep was not only obtained, but the œdema disappeared, and the quantity of albumen in the urine was notably diminished. Labor followed in due course, and was in every respect normal, and the puerperium was free from any complication. Since then Burduzzi has always prescribed chloral in the last month of pregnancy, when there is much œdema, and the urine is scanty and albuminous, as a prophylactic against eclampsia. In a man, 45 years of age, affected by simple nephritis, chloral in doses of 3 grammes a day procured great relief in a short time, and the albumen almost entirely disappeared from the urine. In the so-called physiological albuminuria, chloral is also useful, as the author shows by the case of a man in whose urine albumen was almost constantly present. Burduzzi points out the need of more exact studies of the action of chloral on the renal tissue.—*Jour. Am. Med. Association.*

SALICYLIC ACID A CURE FOR TIC DOULEUREUX. —We frequently meet in our practice cases of tic douleureux, that often so exceedingly painful neuralgia of the fifth nerve, where an operation seems to promise the only radical cure. If we hear of a remedy which is said to have the same effect as the surgical interference, we become doubtful; but if no less reliable authority than Prof. Nussbaum assures of the fact, our hope increases. Recently a number of such cases had been sent to N. for the purpose of having the operation performed, and, after a number of carefully-instituted experiments, this great surgeon recommends a trial with salicylic acid before proceeding to stretching or to resection of the nerve. In all the recently-sent cases he first tried this remedy, and he foun it in every one a radical cure; not only a palliative effect, but really an utter disappearance of the painful disease, was the result in every case. Especially in cases of rheumatic nature, N. is positive of having discovered in salicylic acid a specific for tic douleureux. He administered the drug in the following manner: ℞.—Acidi salicylici, grs. 3⅓ ; sodii salicylatis, gr. 32 ; M. ft. pulv. Within 24 hours the patient takes from four to six of such powders.—*Med. and Surg. Reporter.*

A PRACTICAL POINT IN THE TREATMENT OF PLEURAL EFFUSIONS.—Dr. Broadbent *(Lancet)*, in a clinical lecture, says that when he hears distinct bronchial breathing generally over the chest in cases of pleural effusion, he feels sure that a consoildated lung is immersed in the fluid, and he consequently does not tap unless the symptoms are so urgent as to demand interference. A solidified lung can not, of course, expand, as does one which is simply collapsed, or even compressed, unless it is bound down by adhesions ; and experience has shown him that, on the resolution of the pneumonia, the fluid is usually rapidly absorbed.

He seems to hold the sound views that, with grave symptoms, a pleural effusion should be withdrawn, whatever the complication ; that the course of moderate effusion may often be shortened by tapping ; but that, if the lung be consolidated—one evidence of which is the persistence of bronchial respiration over the whole, or a large part, of the chest—it is better to wait, if the condition of the patient warrants such a course.—*Boston Med. and Surg. Journal.*

CHLOROFORM IN LABOR —The subject of the use of chloroform during labor continues to give rise to diverse views on the part of obstetricians, though the great majority are on the side of its employment with certain limitations. One of the limitations is the prohibition of full anæsthesia, unless it be at the moment of delivery. Up to that time it is properly employed in small quantities merely to alleviate pain without producing un-

consciousness. We have no doubt of the entire safety of this plan. Nor do we doubt that it is preferable to ether for this purpose. There appears to be no danger from chloroform, at least when used in this mode, during the throes of labor. On the contrary, the condition of labor appears to exert a remarkable protective influence against chloroform accidents. In a recent discussion in the St. Louis Obstetrical Society reported in the *Courier of Medicine*, these views were sustained by the members The following remarks by Dr. Papin on that occasion may prove interesting to our readers :

"I have used anæsthetics in labour very extensively. With Dr. Engleman, I play with chloroform in the first stage of labor; I become a little more earnest in the second stage; and when the child's head begins to come out, I give a full dose and produce anæsthesia."—*Pacific M. and S. Jour.*

TREATMENT OF EPILEPSY.—The *Fort Wayne Medical Journal* gives the following formulæ in epilepsy :

℞ Ammonia bromide.....
Elix. valerianate ammonia. aa ʒ ij,
Fl. ext. stramonium.....ʒ ij,
Glycerine.....ʒ ij,
Syrup auranti cort. .....ʒ iv,
Aqua dest.....ʒ v. M.

Sig.—Tablespoonful before meals. In addition to this take from grs. xxx to grs. lx of potassium bromide at bed time. Preface this treatment with an anthelmintic combined with an active cathartic and see that the bowels are subsequently kept in a soluble condition. The writer adds the prescription of a former colleague, which he endorses, not only in epilepsy, but many other diseases of the nervous system. He asserts that it will quiet the most excited lunatic :

℞ Bromide of sodium.....ʒ j,
Bromide of zinc.... ...grs. xxx ij,
Glycerine..... .....ʒ j,
Aqua cinnamomi.....ʒ vij. M.

Sig.—A tablespoonful three times a day in half a wineglass of water.

PHOSPHATE OF SODA IN HEPATIC COLIC. — Dr. Briston in the *Medical News*, says :—Apropos of the recent discussion in the New York Surgical Society, as published in your issue of January 31st, you are at liberty to publish the following notes of a case occurring in the rural districts :

Mrs. J., aged 28, was seen on the 22nd of October, 1884. Found her suffering intensely, the pain being referred to the region of the gall-bladder. The patient herself was firmly of opinion that she was suffering from gall-stone, and said her sister had suffered in the same way, discharging the stones a few days after the attack. This patient further said that she had suffered with similar attacks at intervals for ten years. On the 23d of October, having relieved the suffering of the day before by morphia hypodermically, I put her upon drachm doses of the phosphate of soda three times a day. To quote her own expression, "the region of the liver felt as if it were being ground up." On the 25th, two days after, over one hundred gall-stones, varying in size from a duckshot to a large pea, were discharged per rectum. The present health of the woman is excellent, and she has had no further trouble. The phosphate of soda was continued for several weeks, but has been dispensed with now for two months. What one of the laboratory staff of the profession will give us, the *rationale* of the action of this remedy in this class of cases, and also in catarrhal jaundice, for which it sometimes seems to act as a specific ?

DRESSINGS FOR ULCERS OF THE LEG.—B. F. Curtis, M.D., (*N. Y. Med. Journal*) states that in the out-patient department of the Chamber's Street Hospital, they have had good results from the treatment of ulcers of the leg with Lister's boric-acid dressing, applied with a crinoline bandage.

The leg and foot are thoroughly washed with a one-to-forty carbolic acid or one-to-one-thousand corrosive sublimate solution, and the ulcer itself is washed with a saturated solution of boric acid. Over the ulcer is put a thin gutta-percha tissue, which has been soaking in the boric acid solution, large enough to extend about one-fourth of an inch beyond its edges on all sides. The leg is wiped dry. Sufficient borated or salicylated cotton to take up the discharge is laid over the ulcer, and the rest of the leg from ankle to knee is wrapped with a half inch layer of cotton batting, An ordinary bandage is applied to the foot and from the ankle to the knee is applied a crinoline bandage which has been squeezed quite dry after soaking for five minutes in water. Care must be taken to have the cotton project beyond the upper and lower edges, as they may chafe the skin when dry and stiff. The crinoline will dry in half an hour ; but if time is important an ordinary bandage may be applied over the crinoline and the patient be dismissed at once.

PLASTER OF PARIS TREATMENT OF FRACTURES. —Mr. Christopher Heath in *British Med. Journal*, endeavors to induce surgeons to have more faith in the early treatment of fractures by plaster of Paris than appears as yet at all general, and thus to save the patients and themselves an infinity of trouble. In his paper he quotes from "Aphorisms" of the late Dr. Cowling of Louisville, the following, which he regards as full of common sense :

"Carved and manufactured splints generally fit nobody, and are to be rejected, as not only expen-

sive, but damaging" "The application of the roller-bandage immediately to the skin, whether as as a protective or to prevent muscular spasm, has resulted in such disaster, that it is one of the curiosities of surgery how it could be repeated at this day. When cotton is placed over such a bandage, it forms an absurdity scarcely credible in a man of common sense." "Continued extension, and counter-extension, are, as a rule, not necessary to prevent shortening in fractures. This is best done by removing the causes which lead to muscular spasm; 1st, by as early and complete reposition of the fragments as possible; 2d, by the smooth application of cotton-batting to the limb; 3d, by the equal pressure of a bandage extending from the distal end of the limb to a point beyond the joint above the fracture; 4th, by the accurate fitting of the splints or plastic material for support; 5th, by as little interference afterward as possible."—*Med. Record.*

CROTON CHLORAL IN WHOOPING COUGH.—Dr. W. C. Webb, of Bryantsville, Ky., (*Am. Practitioner*) says that he has employed croton chloral in whoopiug cough with more benefit than he found from almost any other remedy. This drug does not derange the digestive organs, nor effect the vital nervous centres. Patients frequently fall asleep on their chairs after using it. On taking this remedy the patient must be watched lest toxic symptoms be manifested. A child from one to two years old may take 1 grain of the preparation every four hours. One ten years old, may take 2 grains as often. After the first week the dose should be lessened and given at longer intervals. Should there be much gastric irritability, or should the paroxysm be very severe, a few whiffs of chloroform may be given in advance of the croton chloral. This may be repeated only three or four times.

The following formulæ are given for its administration: ℞. Croton chloral, ʒj; tinct. cardamon comp, ; glycerine aa ʒ ij. Sig.—One half teasponful every four hours for a child two years old and under; or, ℞. Croton chloral, ʒ j; tinc. belladon., 5 ij; tinct. cardamon comp., ʒ ij; glycerine, ʒ iij. M. Sig.—One-half teaspoonful.

CAUSTICS IN ENLARGED TONSILS.—Among various caustics for local use in causing shrinkage of tonsillar hypertrophies, Dr. Chisholm (*Virginia Medical Monthly*) has found the chloride of zinc the most available and the least annoying to the patient. He employs it in the following manner: A wire the size of a fine knitting needle, is roughened for a half inch from one end so that it may hold a fibre of absorbent cotton twisted upon it. Dip this into a saturated solution of chloride of zinc and thrust it to the very bottom of the crypt, and keep it there for several seconds. When withdrawn the whitened orifice marks the cauterization. By renewing the cotton for each follicle several may be thoroughly cauterized at the same sitting without causing any annoying irritation to the throat. A very few applications will cause the gland to shrink, as will be seen one week after the destructive cauterization has been made to the interior of the follicles.—*Medical Record.*

SALICYLATE OF SODA IN RHEUMATISM.—Prof. Clarke treated eleven cases of acute rheumatism—all that occurred in his ward at Bellevue—with this drug. In nine of the cases there was early improvement following the use of the medicine. In two cases the amelioration was more gradual. The influence of the medicine in "lowering the fever heat and diminishing the excited pulse were as marked as its power to relieve pain."

The formula used in all the cases is as follows:

℞ Acid salicylic.....ʒ iij,
Soda bicarbonat. ....ʒ ij,
Glycerine.....ʒ ss.
Aq.....ad ..ʒ viii. M.

Sig.—Tablespoonful every two hours the first day, and afterward the same dose, six times a day.

No unpleasant effect of any kind was noticed after the administration of the medicine.—*Medical Record.*

FISSURE OF THE ANUS.—Dr. Kelsey, (*New York Clin. Society*) stated that for the past two years he had not been obliged to stretch the sphincter for fissure of the anus, but had used instead a weak solution of nitrate of silver—never of more than five or ten grains to the ounce. In a recent case the patient was cured by a single application of a ten-grain solution, and in another and very severe and obstinate case a cure was effected in three weeks by this method.

Dr. Abbe has cured cases by the application of the solid stick. He thought the principle was simply to supply a coating of coagulated albumen.—*N. Y. Med. Journal.*

PUERPERAL PERITONITIS.—Dr. Garrigues, *New York Med. Journal*, speaking of the treatment of puerperal peritonitis says: At the beginning of the disease I wash out the uterus once thoroughly in order to remove what septic material might be found there. After this if there is any fetid discharge vaginal douches are used every three hours. Two large rubber ice-bags are placed on the abdomen and kept well provided with ice. But the chief remedy is opium. This is preferably given by the mouth, in one-eighth to one-fourth grain doses, frequently repeated so as to keep the patient free from pain. Brandy and whiskey are also used freely to counteract the effect of the ice and the opium. As to diet only milk and beef tea are given. The bowels are usually left undisturbed;

though at times it thought best an enema may be given.

OPERATIVE TREATMENT IN INTESTINAL OBSTRUCTION.—In the first Harveian Lecture (*Brit. Med. Jour.*), Mr. Thomas Bryant lays down the following rules for operative treatment :

1. Laparotomy should be undertaken as soon as the diagnosis of acute intestinal strangulation is made. There should be no delay allowed for the formation of a specific diagnosis of its cause. It should likewise be proposed in all cases of acute intussusception, and of chronic, which have failed within three, or, at the most, four days, to be relieved by other treatment.

2. In all operations of laparotomy, it is to the cæcum that the surgeon should first advance, since it is from it he will obtain his best guide. If this be distended, he will at once know that the cause of obstruction is below; if it be found collapsed, or not tense, the obstruction must be above. Adhesions or bands are, moreover, more frequently near to, or associated with the cæcum, than with any other part of the intestinal tract. It is also in the right iliac fossa that the collapsed small intestine, in cases of acute strangulation, is usually to be found; and, with this as a starting-point, the surgeon will have less difficulty in tracing up the intestine to the seat of strangulation than if he begins at a distended coil, when it will be a matter of chance whether he travels away from or toward the special object of his search—the seat of obstruction.

3. In a laparotomy, when the strangulated coil of bowel is gangrenous, it should be brought out of the wound, and the gangrenous knuckle resected. The proximal and distal ends of the resected bowel should then be stitched to the edges of the wound, and an artificial anus established.

4. Nélaton's operation of enterotomy should be undertaken in all cases of intestinal strangulation, when laparotomy is rejected or seems inapplicable, as well as in cases of intussusception in which the invaginated bowel cannot readily be released. It should be performed in the right groin, or, rather, right iliac fossa.

5. If laparotomy succeed, the cause which called for it is removed, and the normal action of the bowel is restored. If resorted to early, and as a rule of practice, it is probable that it would be more successful than the treatment by opium, inflation, or purgatives, which has hitherto been in vogue.—*Med. and Surg. Reporter.*

TELESCOPIC CATHETERIZATION.—Dr. A. E. Dugas, of Augusta, Ga., sends us an account of a method employed by him in cases of retention from so-called impermeable stricture of the urethra. He takes the largest sized gum-elastic catheter which will enter the meatus, passing it down until arrested at the narrowed portion of the urethra. It is then withdrawn cut off just above the eye, the edges smoothed off, and then reinserted. When it has passed as far as it will go the end is cut off about an inch from the meatus, and the rest of the tube tied so as to prevent slipping from the canal. Now another catheter is chosen of a size that will just pass through the one *in situ*, and is inserted as far as it will go. It will probably pass farther than the first one, but if not, a smaller size must be selected. If this do not enter the bladder it is to be passed as far as possible and then the eye cut off as in the first case. Now a third catheter passed through number two will almost surely enter the bladder, except in the very worst cases. The larger or outer instruments serve, Dr. Dugas states, not only to ward off and exhaust the contractions of the urethra, but also to act as a stiff handle to direct and guide the smaller and more flexible instruments passing through them.

In connection with this subject the writer states his belief that a great many more cases of retention of urine are due to some derangement of the kidneys than to the urethra. And he says that he has "frequently relieved such cases like magic by a dose of nitrate of potassa, say ten or fifteen grains, twice a day or oftener. The trouble is not that there is too much water in the bladder, but that what water is there is very irritating, and the urethra being more or less strictured revolts against its passage."—*Med. Record.*

RADICAL CURE OF HERNIA.—In one of the latest attempts to effect by operation the radical cure of hernia the "invagination" method has been neglected in favor of procedures aiming either at obliteration of the whole sac or simply at direct closing of its neck. A portion of Sir William MacCormac's surgical address at the meeting of the Associatian at Belfast was devoted to this subject, and several cases were recorded therein of successful excision of the sac. Professor Stokes advocates an operation consisting in the insertion through the incised neck of the sac, near to the external ring, of one or more catgut sutures, and the subsequent approximation of the pillars of the ring by sutures of stronger and more durable material. Mr. Barton of Dublin, cuts down on the neck of the sac, and brings the pillars of the ring together by strong silver wire, which he allows to remain. Torsion of the sac is recommended by Mr. Ball, of Dublin, who, in a paper read before the Section on Surgery at Belfast, gave details of a case in which, after having exposed the neck of a large scrotal tumor, and separated it from the cord, he twisted this portion of the neck with some force.—*Brit. Med. Journal.*

TREATMENT OF BURNS BY BORACIC ACID OIL.—C. J. Bond, F.R.C.S., (*Brit. Med. Journal*) writes as follows: It is now a year since we began

to use boracic acid oil as a dressing for burns at the Leicester Infirmary, at first simply in the form of a mechanical suspension of the powdered acid in olive oil. I have found that 18 grains of powdered boracic acid dissolved in a drachm of hot glycerine, and added to an ounce of olive oil, forms a kind of imperfect emulsion, the glycerine retaining the acid in solution when cold. This can be easily shaken up with oil. This makes a non-irritating and doubly antisceptie dressing, and extensive burns treated thus, and covered with a layer of some antiseptic wool, require to be disturbed but seldom, and if not perfectly aseptic, are far "sweeter" than when dressed with, for instance, the carron oil. As a lubricant for catheters, sounds, etc., this boracic oil with glycerine possesses advantages. It is superior to olive oil because of its antiseptic property; and better than carbolic oil, because it is less irritating and much more stable, boracic acid being non-volatile. Glycerine itself, too, is a dressing of considerable value by virtue of its dehydrating power.

PRURITUS VULVÆ.—There is probably no complication of pregnancy which so much annoys the woman as pruritus of the vulva. So persistent is it at times as to even cause serious mental depression, and the remedy which shall promptly relieve it is a great boon. Dr. Atthill, of Dublin, recommends the following lotion:

℞ Acid carbolici, gr. xx.
Tr. opii., ʒ ss.
Acid hydrocyanici dil., ʒ ij.
Glycerini, ʒ ss.
Aquam q. s. ad., ℥ iv.—M.

Sig.

This is to be applied to the parts by means of a pledget of cotton thoroughly saturated with it and left in contact with the parts. The same lotion, similarly applied, is said to be also useful in pruritus ani.

We have found the application of essence of peppermint to be an efficient remedy. It must be carefully and gently applied at first, and if the smarting which it causes be very severe it may be diluted with an equal quantity of alcohol.

The British Medical Journal alludes to the use of balsam of Peru in this connection as a new triumph in medicine. We had occasion recently to apply it in a case of intolerable pruritus of the vulva, in a woman in the seventh month of pregnancy. The effect was exceedingly satisfactory. It is said to be equally efficacious when the anus is similarly affected. A pledget of cotton is saturated with it and allowed to remain in contact with the parts.

A physician with whom we recently conversed on this subject, declared a saturated solution of borax in laudanum, to be an infallible application, in his experience.—*Medical Age.*

DISPENSARY ADVANTAGES IN PHILADELPHIA,—The dispensary advantages are so extensive in this city, that the poorer and sometimes even the middle classes are enabled to get good medical and surgical advice without pay. Since the two instiutions for advanced medical learning have been established, there is not clinical matter to go around. It is now no uncommon matter to find "interesting cases" hiring themselves out at rental ranging anywhere from twenty-five cents to two dollars per lecture, and if this goes on, the possessor of a well marked case, say, for example of lupus, may regard his face as his fortune.—*Phila. Med. Times.*

AN EXCELLENT COUNTER-IRRITANT.—Dr. Ellwood gives the following in the *New England Med. Monthly:* Some years ago I saw the following counter-irritant in one of the medical journals (which one I now forget), and which in certain classes of cases I have found very beneficial:

℞ Oleum Tiglii.....ʒj
Ether Sulph.....ʒij
Tr. Iodine.....ʒv—M.

S.

This excellent counter-irritant is applicable where it is not necessary to produce too much effect. It is particularly nice for children.

REMOVING A CINDER FROM THE EYE.—Dr. Deming in the *New England Monthly* says: Recently while riding in the cars, I was unfortunate enough to get a cinder in my eye. After vainly trying to extract it myself I went up to one of the brakemen and asked him if he could remove it for me. He lifted the lid and catching sight of the little foreign body, he said very quickly, "O yes!" and pulling from his head a long hair he made a loop of it and passing it over the conjunctiva, quickly removed the particle. The manœuvre was so simple and successful and to me new, that I thought it worth sending to your monthly.

SURGICAL FEVER.—The *Coll. and Clin. Record* gives the following as a mixture used in surgical fever, at Jefferson College Hospital:

℞ Liq. ammon. acetat.,
Liq. potass. citrat., aa ℥j,
Spirit. æth. nit.,
Liq. morph. sulph., aa ℥ss.—M.

Sig.—Dessertspoonful ter die.

If the fever runs very high, gtt. ij tinct. aconit. rad. are added to each dose.

OSMIC ACID IN SCIATICA.—Osmic acid is recommended by James Merces, M. R. C. S., in the Lancet, for sciatica. From three to five minims of a one-per-cent solution is injected by the hypodermic syringe deeply into the parts over the course

of the nerve midway between the tuber ischii and the trochanter major. There may be slight numbness following. In some the effect was marvellous. Out of eighteen cases twelve were given relief for several weeks, when they passed from under observation.

THE TREATMENT OF SICK-HEADACHE.—Dr. W. Gill Wylie, of New York, has produced excellent results with the following method of treatment: So soon as the first pain is felt, the patient is to take a pill, or capsule, containing one grain of inspissated ox-gall and one drop of oil of gaultheria, every hour until relief is felt, or until six have been taken. Dr. Wylie states that sick-headache as such is almost invariably cut short by this plan, although some pain of a neuralgic character remains in a few cases.—*N. Y. Med. Journal.*

REPETITION OF IODINE INJECTIONS IN HYDROCELE.—Professor Tillaux drew the attention of his class, at the Beaujon, to the danger of being in too great a hurry in repeating injections of iodine in hydrocele. It is only at the end of six weeks or two months that we can judge of the result of the first injection, and to interfere before this time is to expose oneself to induce the formation in the tunica vaginalis of those false membraneswhich are so vascular that they bleed on the slightest shock, and thus give rise to hæmatocele and the loss of the testicle.—*Med. and Surg. Reporter.*

CRYSTAL PEPSIN.—The surgical value of pepsin as a dissolvent is well shown in a note in the *North-Western Lancet.* The editor of that journal states that he was once called upon to relieve the distress occasioned by a bladder distended with clotted blood. He injected a scruple of Jensen's crystal pepsin in an ounce of warm water, and had the satisfaction of seeing the patient pass a full stream of urine and disintegrated blood, in less than twenty minutes.—*Med. and Surg. Reporter.*

THE RELATIONS BETWEEN PHYSICIAN AND PATIENT.—A recent number of the *Lancet* contains a thoughtful editorial upon this subject, called out by an unjust charge against a medical gentleman. The subject is a delicate one, but the writer has approached it in a most careful and unobjectionable manner. It is not wholly unnecessary to remind physicians that they never can be too cautious in dealing with a certain class of women, who maliciously involve an innocent man in lasting disgrace. The recklessness with which some of the younger men allow themselves to treat pelvic diseases, without providing the smallest loop-hole for escape in case of unjust accusations, is a constant matter of surprise to those who have learned caution from experience. Short visits, entire absence of familiarity, and a refusal to undertake any procedure in a questionable case without the presence (or knowledge) of a third party—these are the only safeguards. "It is usually advisable to avoid mixing social with professional visits," says the article to which we allude; "a doctor visiting *as a doctor* should play the doctor and not the visitor; he may visit *as a visitor* at another time. In cases of domestic unhappiness or separation he should be doubly cautious."

Enough has been quoted to show the tenor of the remarks. No man who follows out these precepts can fail to conduct himself on every occasion in a manner worthy of the honor and dignity of his profession.—*N. Y. Med. Jour.*

OAKUM AS A SURGICAL DRESSING.—By Robert Leslie, M.D., Belfast (*Brit. Med. Journal*).—Oakum is made from old ship's rigging which has been soaked in tar, and then reduced to its original state of flax or hemp. During the American war oakum was extensively employed in the field hospital as a surgical dressing.

Eight years ago I commenced to use this dressing in the Children's Hospital. Since that time oakum has been in use in all the hospitals of Belfast, and by some is now considered indispensable. I have been using oakum for burns, erysipelas, ulcers, abcesses, and many vaginal displacements; and I think it the best ready-made dressing we possess. One of its advantages is that it keeps down offensive odors. The serum from a wound is drained as it is discharged, and pleasant tarry smell is a great contrast to the offensive odor common in connection with lint.

In amputation it forms a soft and comfortable pad for the stump, and is a good vehicle for the application of antiseptics. In the treatment of abscesses it takes the place of a poultice by dipping it in warm water and covering with waterproof tissue. Its application, after opening an abscess, permits the easy escape of pus, and is conducive to quick healing. In erysipelas I envelope the affected part in oakum, and with such good result that I do not seek another agent.

As to dressing for burns and scalds I look upon oakum as invaluable. It may generally be applied to the granulating surfaces with impunity, and is more easily detached than almost any other dressing. I thus account for the fact: when a dry fibre of cotton is placed beside a fibre of linen under the microscope, you perceive that the cotton is round and smooth while the linen is sharp and angular but on the application of water the case is different. The cotton fibre is found to twist in a spiral manner, while the linen fibre is unmoved. It is a popular theory that cotton does not form so good a dressing as linen, and this hygroscopic difference may account to a great extent for their difference in behaviour when applied to moist surfaces, and the ease in removing linen.

In uterine and vaginal affections oakum can be turned to good account. The healthy effect of this tarry substance applied to the mucous membrane of the vagina is most remarkable. A tonic effect is produced, and the unhealthy discharge is absorbed. In prolapse and other displacements of the uterus when it is difficult or impossible to get pessaries to relieve, you can secure twenty-four hours' respite to your woman by filling the vagina with oakum, and by dipping the first plug in glycerine you gain immensely in cases of subinvolution from the quantity of fluid extracted.

To sum up: oakum is a handy, healthy, and cheap dressing. It is easy to apply, and I think it is antiseptic in the sense of forming a barrier to the ingress of germs to the part to which it is applied. Tar is itself a wholesale agent, a substance of complex composition. It contains creasote, turpentine, paraffin and eupione, and is obtained by the destructive distillation of pinus sylvestris. Carbolic acid has largely taken the place of the cruder compound, but Dr. Whitla says the virtues possessed by tar are not equally enjoyed by its more fashionable rivals. In oakum we have a form of tar dressing which I recommend to those engaged in hospital work.

NEW MODE OF LOCALIZING BULLETS.—In the transactions of the Vt. Med. Soc., Dr. S. J. Allen says:

"Perhaps I may be pardoned if I say, that during the four years of the war I served in the field one year as surgeon of a regiment, two years as Surgeon-in-Chief of a division, and last year as Medical Inspector of the Sixth Corps, and must have seen and examined, if not treated, many gunshot wounds. In all I have examined, be they more or less in number, I never localized a dozen bullets with a probe.

"In nearly all not localized by the finger or sense of touch, I succeeded in fixing with certainty their exact location by the use of the exploring needle.

"I claim that if the bullet did not enter either of the cavities of the body, but lays anywhere in the periphery among the muscles, or other tissues exterior to them, the exploring needle, in the hands of the surgeon, will, by puncturing a reasonable number of times, hit the ball, and convey the intelligence of its exact location.

"Had the exploring needle been used in the case of our late President, the 'encysted wall of pus in the right iliac region' would have been punctured without appreciable resistance, and his surgeon saved the Blissful diagnostic error contained in several of their bulletins, which located the fatal bullet at that exact point with absolute certainty.

"A serviceable instrument for this purpose will be found in the smallest sized exploring needle, with which, all will admit, it is quite safe and comparatively painless to make the puncture.

"It is not unusual to puncture not only the peritoneal cavity, the pleural cavity, and the bladder, but the intestines, and the pericardium, and seldom has harm resulted.

"The probe should be used only to determine the direction the ball took from its point of entrance, and to ascertain if it entered a cavity. Here, I claim, its usefulness ends, and if further used does harm.

"The surgeon almost always has an impression, after an examination, that the ball lies at a certain point. To test this impression, push the exploring needle from the surface directly down to this point. If it does not hit the resisting bullet, try at the next most likely point. If not successful try again. The bullet can be localized in this way many times where all other methods fail. When the needle hits the ball, the surgeon will make the counter incision for its extraction with perfect confidence.

"Supposing that the bullet lies in close proximity to a bone, or is flattened upon a bone, by using a little more force, the point of the needle will be made to penetrate the ball slightly, and will stick a little, and thus convey to the surgeon's hand a sensible difference between bone and lead."—*Med. and Surg. Reporter.*

A POINT IN THE EARLY DIAGNOSIS OF PREGNANCY.—The *Medical Chronicle* quotes from a paper published by Hegar, in the *Prager med. Wochenschrift*, to the effect that this writer has noticed what he considers an important early sign of pregnancy. Hegar calls attention to the fact that during pregnancy the lower uterine segment becomes thinner and softer than in the non-gravid organ. This condition can be made out easily by bimanual palpation, especially if one finger is placed in the rectum while the uterus is depressed from above with the other hand. The sign is said to be nearly constant, but its absence is by no means a proof that pregnancy does not exist.—*N. Y. Med. Jour.*

NEUTRAL MIXTURE FOR FEVERS—Prof. Brinton speaks highly of the following neutral mixture in fevers of moderate type. ℞. Liquor ammonii acetatis, ℥ j.; liquor potass citratis, ℥ j.; spiritus ætheris nitrosi, ℥ss.; liquor morph sulphatis, ℥ ss. M. Sig. Two teaspoonfuls three or four times a day. If the fever is of a higher type, and the pulse full and bounding, tinctura aconiti radicis ♏xii.—xxiv. may be added to the mixture with advantage. —*Med. Bulletin.*

ERGOT IN CONSTIPATION—In the *Allgemeine Med. Zeitung* (Medical Press), Dr. Granzie reports two cases of constipation following the abuse of purgatives cured by ergot. Three doses of ten grains

each were given at intervals of two hours and were followed by copious evacuation. A second stool occurred spontaneously the next day, and after the administration of ergot in small doses for a few days a definite cure was obtained. The constipation was due to atony of the muscular wall of the intestines.—*Louisville Med. News.*

LINIMENT FOR RHEUMATISM.—The *Therap. Review* says: Methyl salicylate (oil of wintergreen) mixed with an equal quantity of olive oil or linimentum saponis, applied externally to affected parts in rheumatism, affords instant relief, and having a pleasant odor, is very agreeable.

Dr. A. L. Loomis says: "A man can take two or three glasses of stimulants through the day as he may feel the inclination, and he may continue this habit for perhaps 25 years without any evident harm accruing from it; but when this man reaches that period of life when the vital powers are on the decline he suddenly finds himself old before his time, for he has all these years been laying the foundation for chronic endoarteritis. I believe, gentlemen, that 50-per-cent of all diseases arise from the use of alcoholic stimulants.

Erichsen says: "The practice of operating in notoriously hopeless cases with a view of giving the patient what is called 'a last chance' is much to be deprecated and should never be followed. It is by operating under such circumstances, especially in cancerous diseases, that much discredit has resulted to surgery; for in a great number of cases the patient's death has been hastened by the procedure which instead of giving him a last chance, causes him only to be despatched sooner than he otherwise would have been."

There are four plans for reducing obesity. 1. The eating of nothing containing starch, sugar or fat, called the Banting system. 2. The eating of fat but not sugar or starch, called the German Banting. 3. The clothing in wool and sleeping in flannel blankets instead of sheets, the Munich system. 4. Not eating and drinking at the same time, or rather with a couple of hours between the eating and the drinking, the Schweninger system.—*Detroit Lancet.*

The oldest physician in the world, Dr. C. C. Graham, died at his home, in Louisville, on Tuesday, the 3rd inst. He celebrated his one hundredth birthday on the 10th of October, 1884. He was the last link which bound the pioneers of Kentucky to the present generation. A man of remarkable physical and mental power, he practiced his profession for a period equal to the lifetime of the average physician, and spent his old age in scientific and literary pursuits.

Chloral hydrate is recommended as a substitute for cantharides, as a vesicant. Sprinkle powdered chloral on ordinary adhesive plaster, melt it with a gentle heat and apply to the part. In ten minutes vesication will be complete. Its advantages are rapidity of action, less pain, freedom from danger of absorption of cantharidin, and the plaster may remain on until the sore is healed.

PAPINE.—Dr. F. O. Young, of Lexington, Ky., says; I have used Papine in my practice and have taken considerable pains to test it and watch its action. I think it superior to any preparation I ever saw used containing opium. It is safe and pleasant and in no case did it ever produce the least nausea.

Dr. James E. Baker (*Med. Record*) recommends cocaine in phthisical cough. Five minims of a four per cent. solution, with a like amount of chloroform, are dropped upon an inhaler and taken at bed time. In two cases of this kind he succeded in giving the patients a better night and making them more comfortable than he had been able to do by any other mode of treatment.

Dr. Forrest in the *Medical News* reports excellent results in a severe case of dysmenorrhea from the hypodermic administration of five minims of a 4 per cent. solution of cocaine. Complete relief was afforded for five hours, and comfort for a much longer time.

—Syphilitic condylomata dwindle away visibly on application three times a day of the following powder dusted over the new growths:

R.	Hydrarg. subchloridi, - -	gr. xxx.
	Acid. Boracic, - - - - -	gr. xv.
	Acid. Salicyl, - - - - -	gr. v.

Chloral hydrate is said by Dr. Roberts Bartholow to be the incomparable remedy for cholera. In many cases of cholera infantum it certainly is of great service.

Dr. F. N. Otis (*Med. Record*), says that he has recently given for three months twelve drachms of the iodide of potassium every twenty-four hours to a patient suffering from syphilis. Entire relief followed from all dangerous symptoms. — *Detroit Lancet.*

To remove foreign bodies from the ear Mr. Jonathan Hutchison recommends the introduction into the ear of a loop of small flexible silver wire. This being hooked about the foreign body, permits of its ready extraction.—*Detroit Lancet.*

THE CANADA LANCET.

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THE TREATMENT OF ASTHMA.

The ordinary physician is prone to regard chronic disease as a thing to be endured rather than cured. Especially is this true in the case of asthma. Why the case of the unfortunate asthmatic should be passed over more lightly than that of sufferers from other chronic diseases, finds an explanation in the notoriously unsatisfactory results of treatment, and the patient's almost certain tenure of life, for the time at least, despite his suffering. When, however, we reflect on the number of asthmatics, and the misery they endure, such indifference is both irrational and cruel. We desire, therefore, to call attention to the nature of the disease, the misery it entails, and the ineffectiveness of common routine treatment, in the hope of stimulating a spirit of more exact enquiry, both as regards etiology and treatment.

Research, and the application of remedies, in any certain direction, usually bear some relation to the importance of the disease undergoing investigation. Here is a disease which afflicts, more or less seriously, millions of the human family, causing much bodily and mental suffering, incapacitating for work or business, and shortening life, yet the physician with all his boasted knowledge has to confess that he is almost powerless to cure, and, at best, only hopes to afford his patient transient relief. We all know how true this is, and how disheartening to the sufferer. He who suffers from chronic consumption, chronic bronchitis, inveterate skin disease, or other troubles equally obstinate, receives more encouragement and comfort at the hands of science than the poor asthmatic. This is all the more strange when we consider that idiopathic asthma is not marked by structural change. This of itself, of course, amounts to nothing, as what at first sight appears simple and easy of accomplishment, on closer examination, may turn out complex and difficult to conquer. Nevertheless it is almost certain the asthmatic has received but scant justice at the hands of the profession. His case has not been examined with due care—causes, immediate and remote, have not been closely inquired into, and he has been altogether too hastily consigned to the limbo of incurables.

It is not sufficient to know that our patient is suffering from asthma. Before we ever attempt to cure him, or afford him transient relief, some important enquiries are essential. This will appear all the more necessary when we remember that the disease is seldom truly idiopathic, but is generally associated with, or dependent upon some other trouble. True, the vast majority of cases may be relieved off-hand, for the time, by one or more of the stock prescriptions for asthma, without any close scrutiny of the case. It is just here where the common error in the treatment of asthma begins. If the attack be the first, or the disease have not yet so far advanced as to have ingrained itself, so to speak, into the patient's constitution, the more culpable is such hap-hazard treatment, since a clear apprehension of the case at the outset might have led to a different and more successful course of treatment. *Cure*, and not temporary relief, should be our aim in all recent cases, especially in the young. To say that asthma is incurable is to utter an absurdity. Some cases are cured spontaneously; some by physiological changes in the constitution; others by a change of residence, and, we hope, not a few, by medical treatment. There can be no doubt, however, that the great majority of chronic cases are incurable, and that the best we can do has no lasting beneficial effect. But even here it is proper to discriminate in order to a choice of remedies in individual cases.

Asthma essentially consists in a spasm of the bronchial muscles which surround the smaller air tubes, with simultaneous congestion of the bronchial mucous membrane. The asthmatic will te

us that his difficulty lies not so much in his inability to take in air, as to expel it. Asthma is sometimes secondary to bronchitis—hence some writers divide spasmodic asthma into two divisions, *idiopathic* and *bronchitic*. A broader division is indicated by *idiopathic* and *symptomatic*. To be able to class any individual case in one or other of these divisions will afford some definite data for treatment. The purely spasmodic case, if such there be, will require management differing from that classed as bronchitic or symptomatic, and *vice versa*. Sight should never be lost of the fact that asthma is often the result of reflex action, the seat of origin being the brain, lungs, stomach, or other organ, frequently requiring for its location much patience and skill. From these observations it will be seen that the proper diagnosis and treatment of asthma is not by any means so light a task as many seem to think. The observance of these, and other points that will readily occur to the thoughtful practitioner, would do a good deal towards lifting the treatment of asthma out of the domain of empiricism, which has always been its bane, to a basis as rational and scientific as that on which rests the treatment of many other disorders.

As to the remedies recommended in the books for this disease there is no end. With no intention of depreciating the value of several old and well tried remedies, we shall now only refer to agents which have recently forced themselves to the foreground. Of these perhaps citrate of caffeine stands first. The dose is one to five grains, dissolved in warm water. It does not appear to be a very dangerous agent, since, in one instance, a patient took 60 grains by mistake, without fatal consequences. Caffeine is said to afford very prompt relief. Arsenic, in the form of 2 or 3 minims of Fowler's solution is reported as making striking cures in appropriate cases. Arsenic has the peculiar property of supporting respiration, as, for example, in making ascents. Its beneficial effect in asthma is no doubt due to this property. Iodide of potassium, is sometimes combined with Fowler's Solution. A valuable combination in the bronchitic form is iodide of potassium, and carbonate of ammonia. Chloral hydrate, either alone or in combination with bromide of potassium, is also followed with excellent results in certain cases. In the form of stagnant respiration with congested lips and nose, and cold extremities, strychnia has been found highly useful. The liquor may be given in doses of from 3 to 5 drops with dilute phosphoric acid. When defluxion from the mucous surface is very profuse, belladonna probably answers best. Medium doses should be given every 4 hours. Grindelia robusta a short time ago was largely used; but failed to come up to expectations, and is now much less used. Quebracho is also a remedy in much repute. We occasionally meet cases of continued distress despite the use of ordinary means. In these cases there is usually much bronchial tumefaction and dryness. In cases of this class nothing can equal one-fourth grain of pilocarpine, with one-fourth grain of morphine, administered hypodermically. The relief is prompt, the tumefaction subsides, and is followed by profuse expectoration. As to change of climate, experience shows that the asthmatic should not seek a dry atmosphere, such as that of Colorado, and the West generally. On the contrary, a warm, moist atmosphere is the most suitable. In mild cases a mere change from one locality to another may create immunity from this harrassing trouble.

THE PREVENTION OF CHOLERA.

With the advent of Spring and summer, the invasion of cholera may be looked upon as one of the probabilities, and therefore the authorities should set about preparations as actively as possible for its prevention. There may be still some doubting Thomases who cannot believe that sanitary measures are of any avail to protect the people from these so-called visitations of Providence. We trust however, that the authorities will not be influenced by any such foolish notions, but will put into vigorus action all the sanitary resources of the country, with the view of stamping out the first approach of cholera to our shores.

If anything were wanting to show the great value of sanitary measures in stamping out this scourge, it will be found in the experience of the city of Genoa, during the prevalence of cholera in in France and Italy. The United States consul at Genoa in a communication to the Home Government on this subject, gives the methods adopted there from which are transcribed the following:

He says: "Since the outbreak of cholera at Toulon and Marseilles a continual purification of

streets, alleys, private and public houses, has been kept up, the most powerful disinfectants being used for the purpose, which made the city all summer, as it is to day, one grand smelling-bottle, of sulphur, chlorine, etc. Impure water, or water supposed to be impure, was shut off from the city; stale fruits and vegetables were seized and destroyed; this year's wine crop was not allowed to be brought into Genoa, and all the wine shops were forced to be closed at 8 p. m., daily. The rules were rigid in regard to household cleanliness, and the use of disinfectants in whitewash, and if the owner of an establishment of any size heeded not the orders of those in authority the work would still be performed, and at the expense of the proprietor. In three hundred cases of cholera before the Aqueduct Nicolas was shut off from the city, there were two hundred and seventy-five deaths, and all the victims had been using this water. Since the water was shut off from the city, the cases were few among those who could obtain good wholesome food. The Sunday excesses among the laboring classes proved a powerful feeder of the epidemic. From this fact it appears that regular habits of work or play are essential in avoiding cholera. The doctors all said that substantial food proved a better means of battling with cholera than doctors' medicines."

The Consul seems especially to consider that above all things pure water is essential in the battle with the enemy. In this contention he will be sustained by all who have given any attention to the subject. In his concluding remarks he says:

"Let a city or town have officials who energetically and fearlessly fight everything which has a tendency to prey upon public health, granted the people abuse not nature; let substantial food be one's daily portion; to these things add a frame of mind prepared to face calmly and bravely whatever trials and vicissitudes may cross one's path, and you have an armor that will, I am positive, in nine hundred and ninety-nine cases in a thousand baffle the type of cholera which has lately raged in Genoa.

MEDICAL HEALTH OFFICERS.

The position of medical health officer of a large city is one of great responsibility and requires the possession of the highest qualities in the individual who accepts it. The incumbent must be a man of good tact and judgment, skilled in his profession, and well versed in sanitary science. Such men are rarely available, especially in view of the miserable salary usually paid such officers in this country. In this city for example, with a population of one hundred thousand, covering an extensive area, with unsanitary conditions in abundance, and sufficient work to keep a medical officer constantly employed, the incumbent (Dr. Canniff) a gentleman eminently qualified for the discharge of the duties appertaining to the office, receives the paltry sum of $1500 per annum for his services, from the city council, and even this small amount is given grudgingly. A supplementary sum of about $600 per annum is also received by him from the Dominion Government for extra work in the compiling of Vital Statistics; but certain members of the council, with a niggardliness which is characteristic, propose to deduct the amount received from the Dominion Government, from the sum which was agreed upon as his salary (viz. $1500). These gentlemen might with the same propriety deduct from his regular salary the amount received by the city clerk for similar work done for the Ontario Government.

We hope and trust that this has not been the the experience of health officers in other cities, for if such is the case we pity them. The gentlemen who have abandoned their private practice to engage in the important and onerous duties of medical health officers, in our large cities, deserve better treatment at the hands of the civic authorities. The services of the medical profession when required must be estimated at their proper value, and the sooner the civic authorities recognize this fact the better it will be for all concerned. No medical practitioner with the proper qualifications for so important an office should be expected to perform duties which require the whole of his time, without receiving at the very least a salary of $2500 per annum. The recent changes in the Ontario Board of Health entail considerable extra work upon the health officer, and the entire duties appertaining to the office demand the whole of his time. He should therefore be properly remunerated. For the credit of the council of this enterprising city, we trust that no spirit of niggardliness will prevent the present incumbent from receiving that just compensation which is so clearly his due.

THE "STRATFORD" HOSPITAL, BRANTFORD.

The opening of this noble charity took place on the 19th ult., and was made the occasion of a very interesting gathering. Among those present were the Lieut. Governor Robinson, of Ontario, and Mrs. Robinson, Col. Denison, Judge Sinclair, Dr. Chas. O'Reilly, Medical Superintendent of the Toronto Hospital, Dr. W. T. O'Reilly, Inspector of Prisons, Mayor Scarfe, of Brantford, and others. The ceremony of presenting the Hospital to the city was performed by the Lieut. Governor. An address was read by Mr. Stratford, the donor, welcoming the guests and referring to the substantial character of the building and its adaptability for the purpose intended. There will be accommodation for from 40 to 50 beds. The building is well appointed in every respect, and especially as to bed-space, sanitation, drainage, etc. He publicly acknowledged the receipt of many valuable suggestions from Dr. Chas. O'Reilly, of the Toronto Hospital, Dr. Digby of Brantford and others. One of the conditions of the gift is as follows :—" The management of the hospital shall be strictly non-sectarian in its character and the institution be open to all citizens of the city, subject of course to the rules that may be laid down hereafter for its conduct ; that no clergyman, priest, or member of a religious sect or other society shall hold religious or other services within its walls or grounds, except a patient shall request the attendance of such, and then only for that patient's personal benefit. He said " that it was not without the most serious consideration, and after making many enquiries from those who had been and were connected with hospital working, that he appended this condition. Hospitals were purely for the relief of the sick and wounded. Cases admitted therein were mostly serious and required urgent and careful attention. If the patient is insensible he cannot require spiritual advice, but if sane, it is he himself who should say if he wants religious ministration. Under this condition the patient has full power to send for any adviser as may wish, but otherwise no religious adviser will be allowed to interfere with him. A Medical Superintendent of a large hospital, to whom he had submitted this condition, said :—' I fully approve of it, and it would be better for the proper working of every hospital were such a rule rigidly enforced, and it is becoming the hospital law in hospitals where it does not already obtain, and where circumstances will admit of its introduction.' "

The Mayor thanked the donor in the name of the city ; and the Governor, after some appropriate remarks, declared the hospital opened. At the conclusion a reception was held and the visitors exchanged cordial greetings with the citizens. The band of the Dufferin Rifles furnished the music for the occasion. We cannot couclude our remarks without again referring to the noble generosity which prompted this act, and it is to be hoped that the example will be followed by wealthy and benevolent persons in other cities in Canada.

THE CHOLERA. — The Medico-Chirurgical Society of Montreal held a special meeting on the 13th ult. to discuss matters relating to the prevention of cholera, and the proposed health bill for the Province of Quebec. The meeting which was a very interesting one was largely attended. Dr. Larocque, city medical health officer, read a short paper on the subjects for discussion. Dr. Howard said that the Dominion Government should enforce the quarantine regulations ; but it remained for the local government to see that proper sanitary laws were enacted and enforced. Dr. Hingston deplored the absence of any health law, and recommended the adoption of the Ontario Act with certain improvements

CHILDREN IN LOS ANGELES.—Dr. Lindley in commenting on the low death rate among children in Los Angeles says :—The reasons for this light mortality are: 1. The diurnal breeze from the ocean, which constantly purifies the atmosphere ; 2. The constant ripening of fruits—oranges and lemons in the winter ; apricots, nectarines, peaches, and berries in the spring ; apples, pears, and grapes during the summer and autumn, and strawberries all the year round ; 3. Every variety of vegetables fresh each month in the year ; 4. The great number of clear days which, " renders possible an outdoor life almost every day in the year."

CHRONIC BRIGHT'S DISEASE.—Dr. H. Corson writes in one of our exchanges that after all the usual remedies now in use for the treatment of Bright's disease had failed, his patient having been

considered beyond recovery, he resorted to a treatment practiced many years ago. The patient was put upon a pill of calomel, digitalis, and squills, of each one grain, to be given three times a day. Morphine, chloral, or both combined, were given at night to relieve pressure and procure sleep. After keeping the system moderately under the influence of the calomel for two or three weeks, the symptoms rapidly disappeared.

STANDARD DISINFECTANT.—In an article in the *Medical News*, January 10th, '85, Dr. Sternberg, U. S. A., suggests a combination of permanganate of potassium with the bichloride of mercury, for common use as a disinfectant and deodorizer. The color of the solution would be a safeguard against its being accidentally drunk. No chemical reaction takes place when these substances are combined; in other words they are perfectly compatible. A solution of two drachms of each of these salts to a gallon of water would be strong enough for all practical purposes. This gives about one part of each to 500 of water.

EXCURSION TO EUROPE.—A number of attractive excursions during the coming Spring and Summer are announced by Messrs. Thos. Cook & Son, the well known tourist agents of New York and London, which are arranged on the most popular scale of prices. Full programmes of these trips, with maps showing the *routes* followed, are to be found in their monthly paper, *Cook's Excursionist*, published at 261 Broadway, New York, which they announce will be sent by mail to any one interested, on application.

NEW YORK STATE MEDICAL SOCIETY.—This society held its seventy-ninth annual meeting in Albany on the 3rd, 4th and 5th ult.. under the presidency of Dr. Sherman of Ogdensburgh. The attendance was, as usual, very large and influential and the proceedings most interesting and instructive. We give a brief synopsis of some of the papers read in another column. The most important event of the meeting was the discussion of a bill to be presented to the Legislature for the establishment of a State Examining Board. A satisfactory decision was arrived at, and it is hoped the bill will become law. The social side of the meeting was well sustained.

SANTONINE—It has been demonstrated that lumbrici live in a mixture of albumen, santonine, and water, but they succumb in a few minutes in an an oily mixture of santonine. Experience has proven the necessity of direct contact. Santonine powder or troches is not a good way of administration, for the santonine is then mostly absorbed in the stomach. The only rational preparation is an oily mixture which is slowly absorbed in the intestines. In any other mode it has a toxic effect with many, but given with ol. ricini is not disagreeable, and very efficient.

GUN-SHOT WOUND OF THE CHEST.—Dr. Powers (*N. Y. Med. Journal*, Jan. 10) reports two cases of pistol-shot wounds of the chest. In each of the cases a bullet of large size entered the lung, in the second case passing entirely through it. In neither was the injury accompanied by marked hemorrhage, nor followed by acute inflammation, and in each the patient made a speedy and perfect recovery. But slight attempts were made at probing the wounds. The wounds were not hermetically sealed, but simply dressed with antiseptic dressings, which were continned until the wounds were healed.

THE TELEPHONIC TELEGRAPH.—A new invention of considerable importance has been perfected recently by Dr. Rosebrugh of this city, assisted by Mr. G. Black, of Hamilton, by means of which telephonic and telegraphic messages can be exchanged through long distances on the same wire simultaneously. One important feature of the invention consists in the entire suppression of the induction which is such a nuisance in the ordinary telephone. Telegraphic signals sent over the wire cause no inconvenience to the telephonic listeners.

INFLAMMATORY FEVER.—The following, which is a modification of a formula by Prof. Gross, is recommended in all cases of sthenic inflammation, except where morphine may be contra-indicated:

℞ Liq. amm. acet. ℥iv.
Spt. eth. nit. ℥j.
Tr. aconit. rad. ♏xx.
Morph. sulph. grs. iss.
Aquæ. ad. ℥viij.—M.

Sig.—A tablespoonful every four hours. Liquor potassæ citratis may be substituted in some cases for the liquor ammoniæ acetatis.

ANÆSTHETIC MIXTURE.—After considerable experience in the use of different anæsthetics, Mr. Lawson Tait has come to the conclusion that a mixture of two parts ether and one of chloroform is the safest and most satisfactory. Other surgeons prefer the A. C. E. mixture; alcohol 1 part, chloroform 2 parts, and ether 3 parts. Both the above mixtures are rapid in their action, not unpleasant to the patient, and produce less sickness than chloroform or ether when given alone.

APPOINTMENTS.—Dr. M. Lavell has been appointed Warden of the Provincial Penitentiary, Kingston, and Dr. O. S. Strange, surgeon to the same institution.

Dr. G. Stewart, of Port Rowan, Ont., has been appointed Assistant Surgeon, Norfolk Battalion of Rifles, *vice* G. W. Stewart, deceased.

Dr. M. I. Beeman, of Centreville, Ont., has been appointed Surgeon, Frontenac Battalion of Infantry, *vice* J. McCammon, deceased, and Dr. R. W. Garrett, of Kingston, Assistant Surgeon.

Dr. Jas. Dorland (formerly of Hamilton Ont.) has been appointed Prof. of Practice of Medicine in Milwaukee Med. College Wis.

The following gentlemen have been appointed License Commissioners for the counties named—J. Gunn, M.D., N. Middlesex, C. M. Gould, M.D., East Northumberland. R. Douglass, M.D., N. Bruce, W. H. Blackstock, M.D., East Simcoe. A. Worthington, M.D., West Huron.

OBITUARIES.—The death of Chas. Clay, F.R.C.S., of Manchester, is announced in our exchanges; also M. H. Newmann, Prof. in the University of Breslau.

Dr. E. S. Gaillard, of New York, editor of "Gaillard's Medical Journal," died on the 2nd ult. The Journal will be continued under the management of M. E. and E. W. Gaillard.

Dr. William Braithwaite, of Leeds, Eng., founder of "*Braithwaite's Retrospect*," died on the 1st ult., aged 78 years. He was the oldest medical practitioner in Leeds.

The death of Prof. Elsberg, of New York, the Laryngologist, is announced in our exchanges.

We regret to learn of the sudden death of Mrs. Dr. Winstanley at Los Angeles, Cal., on the 10th ult., formerly of this city.

REMOVAL OF THE OVARIES AND FALLOPIAN TUBES.—Dr. Trenholme of Montreal (*Can. Med. Record*) reports six cases of removal of the ovaries and Fallopian tubes with recovery in each case, and with good results so far as relief from the pelvic suffering was concerned. The operations were all performed during the year ending April, 1884.

AMERICAN MEDICAL ASSOCIATION.—The 30th annual meeting of the American Medical Association will be held in New Orleans commencing on Tuesday the 28th of April. This is a most favorable opportunity of visiting the Association and the World's Fair at the same time. The rates of travel to New Orleans from all points are as low as can reasonably be expected.

NEW METHOD OF TREATING ACUTE INTESTINAL OBSTRUCTION.—The London *Lancet*, Feb. 14th, in referring to the new method of treatment states that it was first proposed by Prof. Kussmaul. It consists in free washing out of the stomach and removal of large quantities of fæcal matter, and has been attended with excellent results in several cases. The relief from distention is very great, and it also favors subsequent treatment by laparotomy when the latter is necessary.

TREATMENT OF FROST-BITE—Dr. Doane in the *Therapeutic Gazette*, gives the following prescription which he says is excellent in frost-bite, and hopes it may be given a trial:

℞ Cosmoline ℥ i.
Spts. turpentine, ℥ j.
Acid carbolic gtt. x.

The cosmoline and turpentine are rubbed up together in a mortar, and the acid dropped in after. This is being prescribed by Dr. James R. Leaming, and many other able men in New York.

TRANS-ATLANTIC CLUB—A club has been formed recently for the convenience and benefit of Trans-Atlantic students in Edinburgh. The object is to cultivate a feeling of fellowship and secure a means of social intercourse, so that students may not feel themselves strangers in the city or strangers to each other. The rooms which are at 37 Chambers Street will be supplied with home papers and journals.

GRANTING DEGREES IN MEDICINE.—The Uni-

versity of Vermont has announced its intention of granting degrees in medicine to registered British medical practitioners who pass a satisfactory examination in medicine, surgery, and midwifery. The fee to be charged is $30.

HONORS TO LISTER.—The Emperor of Germany has conferred on Sir Joseph Lister the "Ordre pour le mérite" for Science and Arts. This is not only a testimonial to Lister, but also a generous recognition of the claims of medical science, which Germany has not been slow to recognize.

MEDICAL SOCIETY DINNER.—The first annual dinner of the Hamilton Medical and Surgical Society was held at the Royal Hotel on the 4th ult., and was a most successful and interesting reunion. The profession of Hamilton was well represented by many of its ablest men.

CORRECTION.—In our last issue we noticed among new books the work of "McNaughton Jones on Diseases of Women," giving W. Wood & Co. as the name of the publishers. It should have been credited to D. Appleton & Co., New York, as the publishers.

BRITISH DIPLOMAS.—Drs. J. L. Davison (Trinity) and W. D. Oakley (McGill) have obtained the M.R.C.S., Eng.

Dr. W. G. Hardy (McGill), and W. A. Ross (Toronto), have obtained the L.R.C.P. Lond.

Dr. Osler has been granted leave of absence by the authorities of the University of Pennsylvania, and sailed on the 10th ult. for England, where he is to deliver the Gulstonian lectures in the Royal College of Physicians.

SIGN OF SCIATICA.—An exchange says that if the patient be placed on his back and the suspected limb raised and flexed strongly, a pain appearing about the sciatic notch will be a certain pathognomonic sign of sciatica.

Notes and Queries.

Will some physician who has obtained L.R.C.P. and S., Edin., give a brief description of his trip, the expenses of the same and the requirements for the degrees?

Why is it, considering the high standing of the profession, that medical literature in Canada is at such a low ebb, and that only two Canadian works, Fulton's Physiology and Canniff's Surgery are in circulation?

What are the requirements for the position of surgeon and assistant surgeon in the British army, and what are the duties, salary, rank in the service, and pension for disablement? Is a Canadian graduate required to take out the M.R.C.S., Eng., before presenting himself as a candidate?

QUEROR.

An answer to the following questions will be thankfully received.

1. Explain how the stomach is enabled to produce an acid secretion from the blood—an alkaline fluid; have we any means or medicines to assist or promote this action, and what are they?

2. When defibrinated blood is injected *per rectum*, why are not the corpuscles absorbed?

DENVER, Col.

TREATMENT OF IMPOTEFNCE.

Would some reader of the Lancet give his views as to the most appropriate treatment for impotence. The patient is a man 56 years of age, married, good family history, no evidence of syphilis, no venereal excesses, never ill in his life.

NEMO.

MEDICINE CHEST.

Would some of the readers of the Lancet offer some suggestions for a medicine chest for country practitioners. Many of us have to make long trips far from any drug store and it is desirable that we carry as great a variety of drugs as may be necessary, in as small a compass as possible.

Messrs Stevens and Sons have signified their intention of manufacturing a case that will meet all requirements as suggested at a reasonable price.

MEDICO.

[Would not A. A. Mellier's saddle bags meet the requirements? See advt.] ED.

Books and Pamphlets.

THE AMERICAN SYSTEM OF PRACTICAL MEDICINE. Edited by William Pepper, M.D., LL.D., of the University of Pennsylvania, assisted by Louis Starr, M.D. In five imperial octavo volumes, containing about 1000 pages each, with illustra-

tions. Philadelphia: H. C. Lea's Son & Co. Prices per volume, cloth, $5.00; leather, $6.00; half Russia, $7.00.

The first volume of this magnificent work is now before us, and the other volumes will follow at intervals of about four months. It has been in active preparation during the past three years, and is now sufficiently advanced to justify the publishers in calling the attention of the profession to it as a work in which American medicine will be thoroughly represented by its worthiest and most practical teachers. A reference to the list of contributors will show that the most distinguished men in all parts of the United States have united in bringing together this vast aggregate of specialized experience. It embraces the whole domain of medicine, including the departments for which the physician is accustomed to rely on special treatises, such as diseases of women and children, the genito-urinary organs, skin, nerves, hygiene and sanitary science, and medical ophthalmology and otology. It may therefore be regarded as a complete library of practical medicine. Such illustrations as serve to elucidate the subject have been introduced. It is a work of which every American physician may reasonably feel proud, and in which every practitioner will find a safe and trustworthy counsellor in the daily responsibilities of practice. We are pleased to observe the name of Dr. R. P. Howard of Montreal among the contributors, the subject being rheumatism and rheumatoid arthritis.

A MANUAL OF DERMATOLOGY by A. R. Robinson M.D., Professor of Dermatology, New York Polyclinic. New York: Bermingham & Co. Toronto: Williamson and Co.

This volume the author states is intended to be the basis of a future much larger and more original work, and we think it would have been as well, in view of the many works of this kind now in the market, if the author had deferred the publication until he was prepared with his more original work. The present volume is a mere compilation, but as such, fairly represents the status of the science, and is neither better nor worse than others of the kind. It will be useful to those who would prefer a concise yet accurate description of the various affections of the skin.

TRANSACTIONS OF THE MEDICAL SOCIETY OF PENNSYLVANIA.—Vol. XVI., 1884.

Here we have a large octavo of over 600 pages, recording the transactions of the above society for its thirty-fifth annual session, held in Philadelphia on the 14th, 15th, and 16th of May 1884. Many of the papers contained in the volume are of a very high order of merit, and reflect much honor on the medical profession of the old Quaker State. It is not without deep mortification that the Canadian reader is forced to admit the fact of the long rear distance at which our societies stand, in comparison with those of our republican confrères. What is it that we lack? It is not brains; it is not sound initial instruction; it is not individual self-esteem; nor is it overweening modesty. Unity of sentiment and genuine love of country are most probably our greatest defects.

THE INTERNATIONAL ENCYCLOPÆDIA OF SURGERY —A Systematic Treatise on the theory and practice of Surgery, by authors of various nations. Edited by John Ashhurst, Jr., M.D., in six volumes, vol. v. New York: Wm. Wood & Co.

The fifth volume of this admirable work on surgery embraces surgical affections of the head, eye, ear, nose, face, mouth, palate, tongue, jaws, teeth, neck, air passages, chest, breast, abdomen, and hernia. The present volume is quite equal to any of its predecessors, and fully sustains the encomiums already bestowed upon the previous volumes. Those who have not already done so, should immediately subscribe for this magnificent work on surgery.

THE ELEMENTS OF PATHOLOGY.—By Edward Rindfleisch M.D., translated by W. A. Mercur M.D. Blakiston and Son: Philadelphia.

It is a great boon to those who have not time to read all through large books, to fall in with one containing much good matter. Rindfleisch's "Elements of Pathology" is verily one of this sort, a real *multum in parvo*. Every page abounds with valuable instruction, which will not fail to repay the attentive reader for the time he may devote to its perusal.

Births, Marriages and Deaths.

On the 9th ult. H. L. Kent, M.D., of Wallace, N.S., aged 54 years.

On the 7th ult., L. G. Turgeon, M.D., of Montreal, aged 48 years.

On the 18th ult., Dr. Henry Hanson of London, aged 61 years.

On the 20th ult. George E. Richardson, M.D., of Chatham, Ont., aged 45 years.

On the 20th Nov., 1884, W. M. Brett, M.D., of Arkona, Ont., aged 30 years.

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Original Communications.

UTERINE TUMORS.

A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N. B.)

CASE I.—Mrs. S—æt 40, multipara, widow, last child 10 years of age. The patient was sent to me Sept. 29th, 1875, by Dr. White, of Hartland, N.B. She had been always strong and healthy till three or four years ago, when she began to have an increased flow at the meustrual periods and at the same time noticed a hard lump somewhat to to the right of the lower abdomen. A year ago she suffered severe pain in the abdomen and back during two or three catamenial epochs accompanied with much flooding. Since then the quantity of blood lost has been gradually growing less, while there has been a constant watery and mucous discharge. For about two years micturition has been frequent, though the urine was natural-looking and the bowels had to be kept very loose in order to have any passage.

Present condition.—Fairly well nourished. P. 100 and rather feeble. She complained of an unusual amount of pain since her arrival in Fredericton, probably due to her journey in the cars. On examination a large, smooth, semi-elastic tumor was found completely filling the pelvis, its lower end being exposed to view on the separation of the labia. Its surface was found united in places with the vagina, but the adhesions could be readily separated with the finger. A firm hard mass was felt through the abdominal walls, occupying the hypogastric region and reaching fully up to the umbilicus. As the menses had ceased about a week before and the patient was anxious to have an operation at once I decided to accede to her wishes.

Sept. 30th. Operation.—Chloroform was administered; assisted by Dr. Coulthard. As it was impossible to get fairly at the neck of the tumor on account of want of room for the hand, I first sliced off perhaps one-fifth of the thickness of the tumor longitudinally. I then could feel its base apparently attached to the left anterior part of the cervix, and being about three or four inches in diameter. Then by means of traction with very large toothed forceps, and the use of a curved blunt bistoury set in a long handle, about two pounds of the mass were removed, leaving rather more of a stump than I could have wished. The patient however became considerably collapsed, though the loss of blood was not so very great, and I was obliged to desist from further efforts. About two hours were occupied in operating. The abdomen seemed to have flattened down completely during the operation, so that little or nothing could be felt there. The vagina was plugged with cotton wool, and ¾ gr. morphine administered as a suppository.

Oct. 1.—Rested fairly well; vomited a good deal; passed water once; P. 112; some offensive discharge; cotton wool tampon removed. There has been very little hemorrhage. Vagina to be syringed with warm carbolized water every three or four hours, ʒ j. ad. Oj.

Oct. 2.—Vomiting continues troublesome. Not much pain. P. 108. Discharge very fetid. Injections to be continued frequently.

Oct. 3. Doing well. P. 100; discharge as before.

Oct. 4. Ate potato yesterday, and bowels are a little loose to-day. P. 108. Quinine mixture ordered, also careful dieting

Oct. 5.—Bowels better. P. 104. Three bits of sloughy tissue came away yesterday. Discharge still offensive.

Oct. 7.—Discharge less foul for last two days.

Oct. 11.—Discharge is lessening. P. 100. Patient sat up three hours to-day.

Oct. 18.—Discharge very slight. Patient sits up all day now, but looks rather pale and weak. Iron added to quinine.

Oct. 26.—Has been out of doors several times. Wishes to return home and may do so.

On examination I found the entrance to the cervical canal close to the right and posterior side of the upper vagina. The stump of the tumor filled up a good part of the latter and was adherent to

it in places. These adhesions were easily broken down with the finger. Directions were given to get Dr. White to separate any such that might re-form, a few days after getting home.

My patient was so much improved by the operation, that two or three years afterwards she ventured once more upon the sea of matrimony and became Mrs. D. She got along very comfortably until about a year ago, when she began to suffer from a nasty filthy discharge, accompanied by the feeling of something in the vagina. She has also had some irritability of the bladder. Her general condition however has been good. On examination I found a tumor filling the upper three-fourths of the vagina, and attached broadly and firmly to the latter at its posterior and lateral surfaces. I could not well get at the attachment to the cervix uteri on account of the size of the tumor and its extensive adhesions. The fundus of the uterus could be felt through the abdominal walls in the right hypogastric region, reaching nearly to the umbilicus.

April 12th, 1883. Operation.—Chloroform was administered, assisted by Dr. Coburn, of Fredericton. I first cut a slice from one side of tumor as before, in order to reach its uterine attachment, which I now found to be only about 1¼ inches in diameter. This was first severed, then by dint of traction with forceps, cutting with scissors and knife, previously described, and tearing away with the fingers, the whole mass was slowly detached from the walls of the vagina and removed.

Great care was needed during this procedure to avoid penetration of the thinned recto-vaginal septum. The operation lasted about three hours, and I was ably assisted by Dr. Coburn in its successful accomplishment. Although the loss of blood was comparatively slight, yet the patient suffered considerably from the shock, as after the first operation. Her general condition, however, was better on this occasion previous to operating, and she rallied in a short time. The vagina was tamponed lightly with some pledgets of salicylic silk wrapped in carbolized gauze The amount of tumor removed was about equal in size to a fœtal head at full term.

April 13.—9 a.m. Doing well, had ¼ gr. of morphine last night. Some vomiting, P. 76, T. 99°. Tampon removed. Vagina to be washed out three or four times a day with warm carbolized water.

April 14.—P. and T. as yesterday.

April 15.—Less discharge since operation than before. Some looseness of bowels, attributed to her taking some beef-tea yesterday. She states that she is always easily upset by changes of diet. P. 88, T. 99.5°. Paregoric in drachm doses pro re nata for the diarrhœa. Also to have dry farinaceous food.

April 16.—Bowels better. P. 84, T. 98.8°.

April 19.—Discharge is very slight. P. 80, T. 98.8°. May sit up a little, and can have a boiled egg and a potato every day.

April 24.—Catamenia came on to-day, being the regular period for them. P. and T. normal. Sits up several hours every day.

April 29.—Has been going about the house for two days. Menses have ceased. On examination the cervix felt large and expanded, the whole uterus also seemed heavier than normal. No trace of tumor found anywhere, unless it might be two or three small hard prominences at the upper and posterior part of the vagina, of the size of split marbles. Some purulent matter was also found in the vagina. The carbolic injections to be continued two or three times daily. Asks to go home to her family. May do so tomorrow. December, 1884. I received a note from the patient stating that she seemed perfectly well and entirely rid of the old trouble.

CASE II.—May 29, 1880. Mrs. H. æt 39, multipara. The youngest child is six years old. Generally healthy till eighteen months ago, when she began to have menorrhagia, and the intervals between her periods became shorter than usual. During the last six months a colored dischage has been present about half the time.

Present condition. Countenance pale, rather thin in flesh, complains a good deal of back-ache, pulse weak. On examination, a small, firm polypus was felt in the cervical canal, about the size of a large hazel-nut. The uterine cavity measured 3½ inches.

Operation. Chloroform was given because the patient was very nervous. The polypus was removed by the scissors, and a piece of cotton wool wet with carbolic acid and glycerine passed into the cervix, and one or two dry pledgets applied over it.

May 30.—Cotton wool removed. Warm carbolized injections to be used three or four times a day.

June 21.—Patient did perfectly well for a week

or two after the operation, but for a week past she has had pains in the back, accompanied with menorrhagia. On examination, a rather soft, solid mass was felt pressing down into the upper cervical canal anteriorly, which at first thought I suspected might be the somewhat inverted wall of the uterus. The sound however could be passed 2½ inches beyond its lower border of union with the body of the uterus, and I therefore decided that it was a tumor in the wall of the latter.

Operation. Chloroform was administered assisted by nurse. The presenting surface of the mass was seized with a vulsellum forceps, and with the help of blunt scissors and fingers, the tumor was gradually enucleated. It proved to be about the size of a small orange. The free surface measured about 1½ inches across, the remainder of the tumor of course having been embedded in the anterior uterine wall. Very little hemorrhage attended the operation. Pledgets of cotton wool were applied as before.

June 22.—Cotton wool removed, carbolized injections to be used three or four times a day. Little or no disturbance from operation, pulse and temp. being as they were previously.

June 25.—Doing well, very little color in discharge and she suffers no pain.

June 30.—Was up about the room two days ago without leave, and since then there has been some bloody flow.

July 2.—Discharge has ceased, the patient is up and dressed.

July 17.—Has continued free from discharge, and left for the country to-day.

THE MANAGEMENT OF PNEUMONIA.

BY M. C. ATKINSON, M.D., BRISTOL, N. B.

Perhaps there is no disease about the treatment of which physicians differ more than pneumonia. There have been, and there still are, two general modes of treating this disease. The first, the antiphlogistic treatment: the second, the expectant plan. By the first it is hoped to cut short the course of the disease or stay its progress. To this end tartar emetic, aconite, and veratrum viride are administered and venesection performed. By the second plan we hope by careful watching, by restraining the violence of the fever—by good nursing, dieting, and a careful attention to hygienic conditions, to guide the patient through the crisis back to health. In order to reach the subject in a practical way I shall narrate briefly the history and treatment of three cases, and conclude with a few remarks upon the same.

Case I.—February 6, '84, I was called to see J. H., aged 30, a strong, full-blooded, vigorous man; found him suffering from pleuro-pneumonia. The day previous he was attacked with chills, violent headache, and sharp stitch-like pain in the side. Pulse 120, temp. 105°, resp. 36. The middle and lower lobes of the right lung were consolidated. Gave minim doses of tr. aconite rad every two hours combined with three grain doses of quinine; pulv. Doveri., grs. viii, to be given occasionally to relieve pain. Applied mustard over the whole of the right lung, to be followed by hot wheat-bran poultices, changed every two hours; bled to ℥xx. Saw patient three hours after bleeding; resp. 32, temp. 104½, pulse 112, very soft and full. Expectoration, which has been profuse and "rusty," almost stopped; cough much less severe; delirium and subsultus developed.

7th, Patient much more delirious; mouth dry and parched; pulse 133, temp. 103. resp. 32. Stopped aconite and ordered tr. digitalis and am. carb., continuing quin. sulph., grs. iii, every four hours; also to have six ounces of brandy in milk daily. For four days and nights the delirium continued; chloral hydrate and bromide of potassium, single and combined, within the limits of safety, failing to produce sleep till the fifth night after the bleeding, when he fell into a slumber so profound that he had to be awakened by his attendants. On the fourth day after the bleeding the consolidation had almost disappeared. Acute pain from pleuritic adhesions came on, which was relieved by strapping the chest with adhesive plaster. Under the digitalis the pulse fell from 133 to 112 on the second day after the bleeding, and on the third had fallen to 100. The patient was much exhausted on recovering from the delirium. The pulse remained at 100; tongue brown, dry and parched. He also suffered from moderate diarrhœa, which I did not think proper to check. As the delirium went on I increased the daily amount of brandy to eight ounces; also gave him all the milk he could be made to take. The recovery was very tedious.

Case II.—On the same day that I made my

first visit to Case I, I was called to see a niece of his, a young woman aged 19, of robust habit. I found her suffering from the same disease, having also been attacked the day previous. Her pneumonia was but slightly complicated with pleurisy. There was extensive consolidation of the right lung, extending from the lower portion of the upper throughout the middle and lower lobes of the right lung. Sputa "rusty" and tenacious, tongue dry and brown, hectic flush on each cheek; resp. 44, pulse 130, temp. 104⅘. I also found congestion of the lower lobe of left lung posteriorly. The same treatment with reference to mustard and poulticing was pursued here as in the preceding case. I also gave the patient two grain doses of quinine every two hours, and am. carb., and tr. digitalis, in ten grain and ten minim doses respectively, every four hours.

February 7. Again saw patient; pulse 135, temp. 103, resp. 48. Crepitation over the upper lobe of the right lung becoming coarser; fine crepitation over a small portion of the left base posteriorly. Ordered four ounces of brandy in milk daily; digitalis and am. carb. to be continued.

8th. Pulse 144, temp. 102½, resp. 52. Taking a good deal of nourishment. Ordered all the brandy that she could take. Continued the am. carb. and digitalis; ordered frequent sinapisms to the whole chest. The pneumonia of the left base, luckily for the patient, did not extend.

10th. Patient remained in much the same condition, and I regretted that I had not used the lancet. I did not see her again till the 12th, when I found that a great change had taken place. Incredible, as it may appear, the pulse was 63 and occasionally intermitted, temp. 101, resp. 24; tongue beginning to clean. I immediately stopped the digitalis, am. carb. and brandy; kept up the quinine, and ordered free nourishing liquid diet. The patient made a very rapid recovery, and was able to attend her ordinary work a fortnight before her uncle got out of bed.

CASE III.—*F.b. 27.* Was called to see a man, aged 27 years. He was a large, full-blooded, powerful man, weighing over 200 pounds, somewhat addicted to drinking. He had been attacked that day with severe pain in the right side, embarrassed and painful breathing; pulse 112, temp. 102; some diminished resonance on affected side and tubular breathing, but no crepitation; an occasional cough, but no expectoration. Gave a saline purge and bled fully twenty ounces; gave tr. aconite rad., ♏ iv., every four hours; ordered mustard and poultices to side alternately.

March 1st. Again saw patient. Crepitation now distinct over the anterior portions of the right lung, middle and lower lobes; abundant rusty sputa; pain in side somewhat easier; pulse 100, temp 102½.

3rd. Patient in much the same condition. Pulse, however, running up to 115, temp. 102, respiration laboured.

4th. Pulse and temperature the same, respiration very laboured. Marked nervous prostration, delirium and stupor; cannot answer intelligibly. Discontinued aconite; ordered am. carb., vin ipecac and quinine, also six ounces of brandy daily.

5th. Pulse 95, temp. 100, respiration less laboured; patient more rational.

9th. Very great improvement in every way; still very weak.

13th. Convalescing. The patient recovered very slowly, the lung remaining consolidated for a long time.

So much for the history of these three cases. Now, I think the point upon which we differ most is the question of venesection. This question has been discussed, and is still being discussed, by some of the best men in the profession, and they differ very much in opinion. Now, what mainly are our objects in bleeding in pneumonia? To prevent death from suffocation; to unload the right side of the heart. Is it a common thing for death to occur in pneumonia from suffocation? For my own part, I have never seen death from this cause, and have read of very few, and I believe that the experience of the profession generally coincides very nearly with mine. But some claim that bleeding favours absorption? This is easily affirmed, but difficult to prove. In case first absorption occurred very rapidly. In my third very slowly. Both were good subjects for bleeding; in both I employed venesection. In case second, a good subject for bleeding, I withheld the lancet; but absorption occurred here also with extreme rapidity. Now, I have treated a large number of cases of pneumonia in the last two years, in two only have I employed venesection, and, of all my cases, these were the most prolonged and

tedious, and in these the nervous phenomena occurred in a manner most marked, when contrasted with those cases which I had treated upon general principles. Now, it is also said of bleeding that it cuts short the disease if employed in the congestive stage. To this I can say, it may sometimes; it does not always. In case third I employed it in the congestive stage, with the result narrated. The pneumonia went on. Still in the case of a strong, full-blooded young man, seen early, and having marked dyspnœa, with the blueness of the face and a turgid condition of the venous system; with a small pulse and laboured action of the heart, showing that the right ventricle was distended and, in the left, scarcely any blood upon which to contract, I cannot but think that the lancet should be used. But how much blood will you take? Some say eight, some say ten, some twenty, some thirty, thirty-five or forty ounces of blood at once. I consider this a point of the greatest importance. I believe that in pneumonia an exception must be made to the general rules laid down with reference to bloodletting.

The average amount of blood in an ordinary man is eighteen pounds; in a full-blooded man of good size we might approximate the amount at twenty pounds. In an extensive pneumonia of one lung you will have four or five pounds of blood, or of material from the blood, thrown out as exudation; in double pneumonia nearly double that amount, viz., eight or ten pounds, leaving in a full-blooded man fifteen or sixteen in single, and ten or twelve pounds in double pneumonia. Now, this fifteen or sixteen pounds of blood in a single pneumonia is not only very much less than what is necessary to carry on the work of the economy, but it is also much deteriorated by the products of inflammation on the one hand, and by defective aeration on the other. Now, what must be the result if you take one and a-half, two, or two and a-half pounds of blood from the veins of a man when it has already been so fearfully drawn upon? The brain, we are told, requires one-seventh of the blood, viz., something over two and a-half pounds. Taking the amount in exudation and making a little calculation, you will find that you have a reduced blood supply to the brain of nearly one-half. Now, you will find, if you do this, the nervous symptoms, which may have been mild before the bleeding, will become pronounced in a short time after the bleeding. Take a man in full health and bleed him to the extent of seven pounds—few of us would care to do it—and yet that man is able to reproduce the lost blood in a short time, because his powers of assimilation and absorption are unimpaired; but the man who suffers from pneumonia is in no such condition, the whole system is profoundly disturbed, and the blood-producing powers almost at zero; and yet there are some who would not hesitate to take two or two and a-half pounds of blood. Now, if this is a strong case in single pneumonia, what must it be in double pneumonia?

Here you have eight or ten pounds of exudation taken from the blood, ten or twelve pounds left in the body—say you have twelve pounds left in the body. You take away two more; you have ten left—just half the blood, and loaded with the products of inflammation and very improperly aerated. It does appear to me that a physician should be sure of his case before he would adopt such heroic measures. Bad as is the mortality of double pneumonia under the cautious, conservative, and I believe, judicious treatment of late years, I am persuaded that it would be woefully increased by such a measure. Even in the case which I have drawn as being one in which it would be appropriate to use the lancet, the quantity taken should not be large: not above eight or ten ounces, or, at the outside, twelve ounces. In the cases in which I adopted it I believe I withdrew too much. I am led to this conclusion by the very marked nervous prostration and tedious convalescence which followed the measure. Another point: When should you bleed in pneumonia? In the congestive stage. It is then that the right side of the heart is loaded; it is then, if at all, that you may hope to cut short the disease; it is then that you may hope to lessen its severity. If you wait till exudation is completed and then bleed, you only further debilitate a patient already sufficiently debilitated, and narrow his chances of recovery.

AN ADDRESS READ BEFORE TRINITY COLLEGE MEDICAL SOCIETY.

BY G. A. BINGHAM, M.D., TORONTO.

Demonstrator of Anatomy.

MR. PRESIDENT,—When informed that your committee had honored me by appointing me to

read a paper before you to-night I was at first puzzled, and then a feeling of actual helplessness began to overcome me as I took in the full force of the situation. In order to read a paper one must have a subject. The subject upon an occasion such as this should be fresh and entertaining, for if I understand properly the object of these reunions—these open meetings of your society, we are not here to listen to the dull technicalities of science or philosophy, nor to have exhibited to us the awful niceties of the surgeon's blade, nor to endure panegyrics upon the virtues of Gossypium or Jaborandi. All these delicacies are, no doubt, done full justice to at your regular meetings. But upon occasions such as the present, whether as friends, medical students, or practitioners, we are for a time to throw aside the cares of everday life, and banish from our minds all thought of the morrow's burdens, and while this hall resounds with the inspiring strains of old "Litoria," the physician is to fancy himself once more, as in "Auld Lang Syne," sacrilegiously carving his name in undying letters upon the furniture of his alma mater. And those friends who have honored us by their presence to-night are to wish that they, too, had been medical students. No wonder, then, that I was puzzled to select a subject suitable for such an occasion. In my despair I appealed to your worthy President, and he blandly suggested that in my paper I should attempt a solution of the conundrum of the nineteenth century. Fellow students you will perceive at once the inappropriateness of such a subject, for, while we all concur in the determination never to give up that conundrum, we are all equally agreed that its solution, like many other grand mysterious dispensations of Providence, is completely beyond our powers. Thus thrown upon my resources I thought of writing an essay on "How to prevent the cholera invasion," but, as my remarks would probably never have been even heard of by the International Convention, fortunately for you I abandoned that idea. Then the idea of writing up the trials of medical students suggested itself to me. The medical student! The professor's pride and the policeman's pet—that anomalous being so little understood by those among whom he lives,—accused of all the misdeeds in the calendar of crime,—persecuted, frowned upon and laughed at by those who may some day invoke the aid of his skill to rescue them from an untimely grave (and it is needless for me to state that assistance will be magnanimously, I may say even cheerfully, extended at the maximum rate of two dollars per bottle). And yet, Mr. President, anyone who is thoroughly acquainted with the actual condition of affairs must acknowledge that we have no class of students who labor more assiduously to prepare themselves for future usefulness;—none who so honestly strive to master the details of that mighty principle which underlies the alleviation of human misery; and none, when occasion calls, who so willingly brave contagious disease and death for the benefit of their fellow-beings. Speaking of medical students one is naturally brought to the consideration of a subject which, did time and your kind patience permit, I should have liked more particularly to dwell upon—I mean the preparation of the medical student for his life work, and what share literary education should have therein." I have no doubt many will exclaim, "The science of medicine is of itself sufficiently extensive to occupy our whole attention." I thoroughly agree with you, my friend. My recollections are too painfully vivid for me to forget the midnight toil and the early hours of the medical student. I cannot yet obliterate from my memory the total absorption of one's mental faculties in the mighty volume of "*Gray's* Anatomy," until one's very hair threatened to partake of the nature of the subject and turn—*Grey*.

Nor do I forget the painful delvings for grains of diagnostic truth in the stony bosom of "Flint,"—and the steadily increasing burden of work as the session approached its close, until one had not even time for those devotions at the shrines of Bacchus and of Venus, which some well-meaning but misinformed people consider so essential to every properly constituted medical student.

Notwithstanding these facts I cannot but believe that, if the preliminary education of a medical student possessed more of a literary character, it would not only enhance his future usefulness, but would increase his facilities for attaining to prominence in the pursuit of his medical course.

We have, to-day, medical men occupying some very high positions in this country of ours. The legislative halls of Canada contain many representatives of our profession. We are all proud to know that a former graduate of our beloved Alma Mater now occupies a position in the cabinet of

Manitoba; and another member of our profession is our representative in England as High Commissioner (some call him our *very* High Commissioner, whatever that may mean). In view of the fact, then, that our fellow-countrymen have been pleased from time to time to select from our midst men to represent them in the councils of the nation, it behoves us all so to prepare ourselves that, should it ever be our lot to be so chosen, we should do honor, not only to our country, but to our profession.

But in what way would literary training be of *direct* advantage to a student of medicine? While the study of classics, ancient or modern, or the acquiring of the romance languages, or the research after great mathematical truths, may not have any direct bearing upon the study of medicine, yet who will deny their influence in strengthening the mind and expanding the intellect? Who will deny that he whose intellect has been cultured and strengthened by familiar intercourse with the philosophers, the moralists, the statesmen, the historians, or the poets, of ancient or modern days, is better fitted to pursue the researches into the mysteries of growth and decline, of health and disease, of life and death?

Undoubtedly a liberal literary education will inculcate habits of study, discrimination and discernment, all invaluable accessories to the student of medicine; and he will indeed be a public benefactor, a servant who has nobly served his country, who will, by some means at present unknown, reconcile the laborious life of a medical student with the attainment of literary knowledge; and he will certainly deserve to have engraved upon his tombstone the epitaph, suggested, I believe, by Mark Twain for his poor old servant, who, in a state of inebriation, fell upon the red-hot stove and, before being rescued, was burned to a crisp: "Well done, good and faithful servant."

In conclusion, gentlemen, I would say: Make the science of medicine your first love, and lovingly array her in the mantle of literary excellence, bedeck her with the gems of culture, adorn her with the priceless diamonds wrested from the bosom of literature; and then, and not until then, will you have done justice to your heart's first love, your chosen science; and then, and not until then, will that science stand forth flashing with the peerless rubies of truth, and, exalted upon a pedestal far above the petty tyranny of prejudice, will receive as homage, the appreciation and admiration of all men.

Correspondence.

TO THE MEDICAL ELECTORS OF KING'S AND QUEEN'S DIVISION.

GENTLEMEN,—Ten years have now elapsed since I addressed you as a candidate for this division,—since which time I have closely attended to your interests as your representative in the Medical Council. Whether I have succeeded in fulfilling these duties—my record is before you; you are the judges.

I have again been solicited by a highly respectable number of my professional brethren to offer myself as a candidate for your suffrage in 1885. It is very gratifying to me to have such a respectable number of my friends come forward, many of whom unsolicited have appended their signatures to my nomination paper. Some time ago I had every intention of retiring from the responsibilities of office, but was so strongly urged once more to enter the arena I could not do otherwise than allow my name to be used for that purpose. Many of you have certainly given me more credit than I deserved for alleged zeal in your behalf. Allow me to state that I have always been devotedly attached to the medical profession—not so much for the emoluments as for the scope which it offers for mental gratification in the cause of suffering humanity, although we sometimes receive the doubtful honor of unmerited abuse from many of those whom we often risk our own lives to serve without any reward whatever. However, we have hours of happiness in the thought of doing more real good to mankind than all the other professions put together. It is altogether unnecessary for me to say much on the duties devolving on the members of the Council. I might say, however, that it is in contemplation to have the Medical Act amended. Some of those amendments I approve of, others seem to me of rather doubtful propriety—such as the increase in our annual assessment. I have not yet seen a medical man in this division who approves of such a step. The law also ought to be amended whereby actions for

malpractice shall be brought within a limited time and security given by the plaintiff for costs incurred in the bringing of such suit. In the majority of cases tried the plaintiff is some miserable creature, with scarcely the coat on his back or even the will to earn it. To say nothing of the trouble and anxiety, the loss to the defendant is very great whether he is successful or not; not unfrequently ruin is entailed and probably his prospects blasted for life. There are other improvements that might be stated, the nature of which I shall not enter upon; but if you should feel at liberty to tender me your vote it shall be my pleasing duty to do everything in my power to promote the honor and dignity of the profession generally.

Thanking you for the confidence you have so long reposed in me, I have the honor to be, gentlemen,

Yours sincerely,
W. ALLISON.

BOWMANVILLE, 9th March, 1885.

Reports of Societies.

ONTARIO BOARD OF HEALTH.

The regular quarterly meeting of the Ontario Board of Health was held in Toronto on the 12th ult.; present: Drs. Coverton (Chairman), Cassidy, Rae, Yeomans, Oldright, and Bryce, the Secretary. The Secretary read a communication from Mr. Crown, of Sault St. Marie, relating to the proximity of the burying ground to the dwelling houses. A communication from Dr. Harris, Medical Health Officer of Brantford, asked if the municipal authorities in Ontario had power to regulate the cutting of ice. Dr. Bryce stated there was no provision in the Municipal Act regulating the cutting of ice, but he understood that Mr. Badgerow was going to submit a resolution to the Local Legislature making provision for the same. The question of preventing the existence of cemeteries within a certain distance of dwelling houses was also to be considered by the Legislature. The Secretary made his quarterly statement of the work done in connection with the smallpox outbreak in Hungerford township. When the Provincial Health Board authorities had entered the affected district the spread of the disease was most effectually stopped. The desirability of establishing a vaccine farm in connection with the Experimental Farm, at Guelph, was discussed and a committee appointed to confer with the goverment in relation to the matter. The Board adopted the following memorial to the Dominion Government on quarantine regulations: That in view of the probable introduction of cholera into this continent, and of the fact that smallpox has been introduced into the province by immigrants several times during the past year, the Board would respectfully submit the following additions to the regulations already in force for preventing the introduction of contagious diseases:

1. Clean bills of health to be issued by the District Medical officers to emigrants purposing to embark at a foreign seaport.

2. Appeal to the Government at home for arrangements whereby the quarantine officers at the various seaports of our Dominion might by cablegram be advised of the departure of vessels from English ports having on board emigrants from infected countries. Provisions also at ports of departure for suitable buildings in which intending emigrants on whom infectious diseases have developed may be cared for until convalescent.

3. Precautions to be observed on board ships carrying emigrants during a time of prevalence of cholera or smallpox. In proportion to number of emigrants carried, space to be set apart in a suitable portion of the ship for an isolation hospital with greater provision for free ventilation.

4. During the prevalence of cholera the premonitory diarrhœa should be carefully attended to; excreta received in vessels containing one pint of a solution of mercuric chloride and permanganate of potash, of the strength of two drachms of each to a gallon of water; body and bed linen, if soiled, to be destroyed, or immediately placed in soak and boiled in same solution.

5. Quarantine stations to be supplied with boarding stations, consisting of suitable wharves and boats for (1) boarding vessels and for transportation of the sick; (2) places of sequestration for those that are well, but have been exposed to the disease during the passage and have not yet passed the period of incubation.

6 Hospitals for the sick with various infectious diseases, to be placed at distances apart, to prevent the germs of one disease being transmitted to another.

7. Vessels on arrival should have the following points established:—(1) Sanitary condition of port

of departure; (2) Sanitary condition at time of leaving; (3) History during passage; (4) Sanitary condition on arrival, with reference to cleanliness of quarters of steerage passengers and crew.

BRANT COUNTY MEDICAL ASSOCIATION.

The usual quarterly meeting of the Brant County Medical Association was held in Brantford, on the 3rd ult. There were present Dr. Marquis, Mt. Pleasant, President; Drs. Philip, Henwood, Griffin, Digby, Winskell, Secord, Branford; Dr. Kitchen, St. George; Dr. Fairchild, Mt. Vernon; and Dr. Davidson, Langford.

It was moved by Dr. Digby, seconded by Dr. Philip, That a resolution which was adopted at a former meeting of this Association in reference to contract practice be rescinded.—*Carried.*

Dr. Philip exhibited a tumor (steatoma) of large size and many years growth which he had recently removed from the shoulder joint. The wound had healed by first intention.

Drs. Digby and Kitchen were appointed to read papers at the next meeting of the Association.

After some routine business had been disposed of the Association adjourned until the first Tuesday in June.

Selected Articles.

OVARIAN TUMOR IN A YOUNG GIRL.

Clinic by Prof. Thomas, New York.

Our first patient to-day is Margaret H——, born in Nova Scotia, aged eighteen and single. The history which she gives of herself is a very striking one in many respects. She says she has been sick for two years, and that up to two years ago she was perfectly healthy. At that time she had a very hard fall, striking flat on the abdomen, and the next day there came on a very severe uterine hemorrhage. This flowing continued for several months—three at the least—and she says she then called in a physician, who gave her some medicine which gradually stopped it. Since then, however, there has never been any return of the menses; but, as time went on, she noticed that her abdomen was gradually growing larger. She is now as large as a woman ordinarily is at the eighth month of utero-gestation, and she says there has been no menstrual discharge for at least eleven months.

The abdomen of this young girl presents, then, a large hard mass, and she comes here to-day to find out what the trouble is. Suppose that, instead of coming to the college, she had gone to the private office of any one of you. You can see at once that very delicate questions would have arisen for you to decide, and that a great deal would have depended on the diagnosis which you made; for the case is one of importance in many ways. In the first place, she might have slipped on a sidewalk of a city like this, and, attributing all her trouble to the fall, might have called upon you for an opinion which would justify her in bringing suit for damages against the municipal authorities for the condition of the streets. Thus, next week I shall have to make an examination in the case of a woman who slipped and fell three years ago, and who ever since has suffered so greatly from dyspareunia, that marital life is a serious burden to her. In consequence of this she is bringing suit for $12,000 against the city, and I shall have to be extremely careful in expressing an opinion as to whether or not the trouble of which she complains is really attributable to the injury incurred in the fall.

Another important point to decide here is, what sort of an abdominal tumor is this, and what connection has the amenorrhœa with it? Perhaps the amenorrhœa may be natural, and the tumor a living one. As to the statement of the patient that it has continued for eleven months, that should have no weight whatever in affecting our opinion of the case. Many instances have, unfortunately, occurred in which the abdomen has been opened and the trocar plunged into a tumor supposed to be ovarian, which proved, to the operator's chagrin, to be nothing more or less than a gravid uterus. If utero-gestation should really exist, and you should express the opinion that this was not the case, or if just the opposite of this should be true, you can readily see in what an unpleasant position you might place yourself. Let me show you, then, how I would advise you to conduct your investigation in a case like this, in such a way as to avoid error and arrive at the truth. The problem you have to solve is, what is the character of this tumor, and what its connection with the uterine hemmorrhage and the subsequent amenorrhœa?

What, now, might it be? It might possibly be any one of thirty or forty different things; but the most of these conditions are so exceedingly rare as to render it unnecessary to take them into account at all. What, then, are the things it is really likely to be? First of all, in every such case you should always, without any exception whatever, think of utero-gestation. Even if it were one of the vestal virgins themselves, let this be the first supposition on which you proceed with your examination.

At the period of pregnancy, when the abdomen is as large as in the present instance, the cervix ought to be quite soft and a little patulous, and the markedly protuberant anterior wall of the uterus

bulging in front of it; while through the os something hard (whether the head or the back of the child) should be felt moving up and down. Instead of this state of affairs, I found on examination here the cervix and uterus of a virgin, and venturing, on account of this, to pass the probe, it entered the cavity, which I ascertained to be empty for two and a-half inches, and in a direction which showed the uterus to be turned backwards. But, notwithstanding all this, the patient might still be pregnant; for this might possibly be one of those rare cases where there is a double uterus. I began therefore, my examination on the outside of the abdomen. If in a case of pregnancy you keep your hands steadily upon the uterine tumor for some time, you cannot fail to detect a hard mass and the movements of the child. Then, with careful auscultation you ought to be able to distinguish the fœtal heart-sounds, the so-called placental *bruit*. The latter is in reality a uterine *bruit*, however, as the sound is caused by the rushing of the blood through the uterine sinuses. Nothing of the kind was found in this case; nor were there any mammary indications, or any other sign of utero-gestation whatever. This hypothesis is, therefore, to be discarded.

Secondly, the abdominal enlargement might be caused by a uterine fibroid; but in that case the tumor would be very hard and unyielding. Here, on the contrary, I can get a distinct wave on palpation. Has the patient, then, ascites, which might perhaps too be due to disease of the liver, or of the peritoneum? If this were the case, there would be perfect resonance on percussion at the upper part of the tumor, from the fact that the intestines would float on the top of the water. There is, however, not a trace of resonance at the top, the percussion-note being perfectly flat at that point, while there is resonance at the sides, much more marked on one than on the other. She has not, therefore, ascites.

We arrive at the conclusion, then, that she is probably suffering from some form of cyst. This might possibly be of the liver, the kidney, or some other organ; but there is one kind of cyst that is so vastly more common than any other that we will be hardly likely to err if we conclude it to be of this character, and that is the ovarian. There are special reasons also for supposing it to be an ovarian tumor. The mass extends fully down to the pelvis, and it has pushed the uterus backward and downward, as we have previously ascertained. To show you how valuable I regard the former of these signs, I will mention that in a case in which I operated about six months ago, as soon as I found that there were intestines between the tumor and the iliac fossa, I confidently asserted that whatever else the growth might be, it was certainly not an ovarian cyst. The result proved it to be an enormous cyst of the kidney, its size being one and a-half times as large as my head.

So much for the diagnosis of the tumor: now for the question of its etiology. Let me caution you in the first place to beware how you give your support to the hypothesis (on which a suit for damages may be based) that because a certain difficulty from which a patient is suffering came after a fall or other injury, that it is the result of that injury. Some time ago a lady consulted me who said that she had a severe fall upon the back, and that profuse uterine hemorrhage had immediately followed. From her account, I supposed that it was probably a typical case of acute retroversion of the uterus; but when I made a vaginal examination, what was my surprise to find that instead of this there was advanced carcinoma of that organ. Yet the patient until that time had never had any hemorrhage or other symptom to indicate the presence of malignant disease. You must be on your guard, therefore, in regard to *post hoc, propter hoc*. I doubt not that the fall was the exciting cause of the hemorrhage here, but do not believe that either the hemorrhage or the amenorrhœa would have resulted if the ovaries had been in a healthy condition at the time of the accident. I am speaking only from experience; but in the light of that I do not hesitate to say that this girl's trouble is not due to any such cause. On the contrary, I believe that at the time she fell she had cystic degeneration of both ovaries. The fall, however, probably did cause the rupture of one or more of the ovarian cysts, and thus gave rise to the hemorrhage; while as the hemorrhage continued, the ovary went on increasing in size.

Finally, as to the prognosis. Unless ovariotomy is performed, it is a completely hopeless one. I need not say how fully established is the point that drugs are utterly useless in this affection. You will doubtless hear of many cases of ovarian tumors which have been cured without resort to the knife; but the explanation of this is that they have not been true ovarian cysts. It not unfrequently happens that a patient comes to an ovariatomist with a tumor of considerable size, but because he thinks it is not at the time sufficiently large to demand removal, he tells her to return to him in six months; yet when she comes back to him at the end of that time the growth may have entirely disappeared. This is because it was a par-ovarian cyst, a simple cyst of the broad ligament, which contained nothing but pure serum; and it is the cases of this character in which the recovery takes place spontaneously, though the cure is generally attributed to whatever medicine the patient happens to be dosing herself with at the time.

This being, without doubt, however, a true cyst of the ovary, ovariotomy becomes imperatively necessary. When, then, shall the operation be performed? At once, I should say. The late Professor Peaslee, one of our highest authorities on the subject, was in favor of postponing the opera-

tion to the last possible moment, on the ground that the patient ought to be permitted to enjoy life as long as she could. But the fact is, that the patient cannot enjoy life with such a tumor. Its presence makes her utterly miserable, and after it has attained a certain size the sooner its removal is accomplished the better; not only because of the inconvenience and suffering which she will be spared, but because her chances of recovery will be much better than if it is postponed too long. The tumor in the present case now, no doubt, weighs twenty-five or thirty pounds, and it is high time that it should be gotten rid of.

I feel almost certain that double ovariotomy will have to be performed here; and for the reason that the patient has not menstruated for eleven months. The fall, certainly, had nothing whatever to do with this, for women are continually meeting with all sorts of accidents and injuries, but they go on menstruating just the same if the ovaries are healthy. It is the cystic degeneration of these organs, and not the fall, which has put a stop to this young woman's menstruating.

CYSTS OF THE UTERO-VAGINAL GLANDS.

Mrs. Ann R——, thirty years old, has been married three years, and has had one child. This is a very acute case compared with most of those that we meet here, as she says she has been sick only eight days. Eight days ago she began to suffer intense pain, accompanied with a burning sensation, whenever she attempted to pass urine, and yesterday she noticed, for the first time, a lump gathering within the vulva. This is the history.

One of the great advantages of a clinic like this is, I think, that many of the cases which you see here are likely to present themselves to your minds when in the future you meet with similar ones in your own practice; and it may be that many years from now the memory of some special case here at the clinic may enable you to successfully treat one of the same character which you then meet with for the first time yourself, and which might have otherwise proved a puzzling one to you. Thus the present case may fix itself in the memory of some of you, just as one that I will now mention did in my own. Twenty years ago a lady from the South consulted me for aggravated dysmenorrhœa; the pain coming on during the first day of the flow and being excruciating. It was before the days of the hypodermic syringe, and her suffering was so agonizing that nothing seemed to give her much relief. After remaining in New York for a number of months without receiving any permanent benefit she returned to her home in the South, where some time afterward her physician removed a small fibrous polypus, hanging by a pedicle from the uterine canal; and after that she had no further trouble. The explanation of the case was, that this little fibroid, being comparatively free in the cavity, had acted like a ball-valve in preventing the escape of the menstrual blood, and thus set up the uterine contractions which caused the patient such extreme pain. Gradually, the fibroid worked itself downward along the uterine canal, until it was finally extruded from the cervix, when its removal became a very trifling matter.

Since then I have never met with a case in which the symptoms were quite the same as in this case until this very day, when a lady came to my office who suffers in precisely the same manner. Whether the trouble is due to the same cause I do not know; but, with the experience of the other case in mind, I shall at all events take the precaution of dilating the cervical canal with sea-tangle, and examining to see whether there is not such a fibrous polypus present; and it probably would not have occurred to me to do this if I had not come across the other case twenty years ago.

In the case now before you which, perhaps, may recur to some of you many years from now, there is a cyst of considerable size under the right *labium majus*, which is excessively painful to the touch; and under the left arm there is a similar, though smaller, cyst.

So much irritation have these cysts caused that there is now quite a severe vulvitis in consequence. If you did not make a correct diagnosis, this case might give you a good deal of perplexity; but, if you recognize its true character, you would find it one of the most curable cases to be met with in practice. These cysts are due to a degeneration of the vulvo-vaginal glands, whose excretory ducts have been closed by inflammatory action. The vulvo-vaginal glands were first described by Bartholinus, after whom they are often called; but, strangely enough, his description was lost sight of for a long time, and they were rediscovered, as it were, by M. Huguier, of Paris, in 1841. When they become inflamed vulvitis, urethritis, and more or less vaginitis, are the results, as in this case, and coitus becomes utterly intolerable. In this condition all sorts of lotions and soothing applications are oftened ordered; but such treatment is absurd, for the reason that the ducts of the glands, as has been mentioned, are closed by the inflammatory action. If we could probe them with the same skill that the oculist does the lachrymal duct, good results might perhaps be secured by the operation; but I have never heard of such a thing being done. The treatment that I unhesitatingly recommend in such cases is to snip off a section of the cyst (having first anæsthetized the patient), and then stuff it with carbolized cotton. This cures permanently, because the gland soon disappears entirely after the operation. The French writers advise dissecting out the gland; but the great objection to this procedure is that a branch of the pudic artery is very likely to be severed in it, and as the artery lies very deep under the ramus of the pubes it is difficult to control the hemorrhage that results.—*Medical and Surgical Reporter.*

GASTRALGIA.

Clinical lecture by Dr. William Pepper, published in the *Medical Times:*

This man a farmer, aged 39 years, has been sick for two years. His principal complaint is of pain in the left side. He has lived in a healthy locality, and has never had chills and fever. The pain begins in the left side and runs back to the left shoulder-blade. If he eats too much he suffers, but the kind of food taken does not appear to influence the pain. An ordinary meal does not make the pain worse, and eating sometimes takes away the bad feelings. Active exercise or riding over a rough road is apt to bring on the pain. The appetite is fair. The bowels are sometimes constipated, but as a rule he has diarrhœa about twice a week, there being two or three loose stools, but these contain no blood. He weighs one hundred and fifty pounds. His best weight was one hundred and sixty-two pounds, but during the summer he goes as low as one hundred and forty pounds.

Let me here refer to this matter of variation in weight. Many persons will be met with who have a wide range of what may be called normal weight. I never like to see this symptom, for it seems to me that those persons who lose flesh so rapidly cannot be made of very good stuff. A person whose flesh is solid and who is living a correct life should maintain pretty nearly the same weight summer and winter, varying perhaps from three to five pounds. Persons will however, be found whose weight varies twelve or fifteen pounds at different periods of the year. With such persons I have observed that sickness goes hard; on the other hand, loss of weight in them is not to be regarded as of such serious moment as it would be in a person who was thoroughly in training and whose flesh was solid and well organized.

In reference to the pain complained of, when this pain is in the right side, we naturally suspect some trouble with the liver—a gall stone in one of the smaller ducts or in the gall-bladder; some congestion in the liver, causing dragging on the suspensory ligament, or irritation of the capsule of the organ. When the pain occurs on the left side, we think of the spleen, the pleura, and the heart, and when, as in this man, the pain associates with some shortness of breathing and overaction of the heart, we are apt to think more particularly of the heart. Examination of the heart shows it to be perfectly normal. There is no enlargement of the organ, no displacement of the apex-beat, and the valvular sounds are free from murmur. Neither is there any evidence of chronic pleurisy. There is good respiratory murmur and resonance over the the left side. Examination of the spleen shows that the organ is not enlarged and that the man has not lived in a malarious district

Before satisfying ourselves that this is merely a neuralgic trouble (possibly a form of gastralgia), some obscure conditions must be thought of. One of the most insidious of these, and one against which we should be continually on our guard, is caries of the spine. Caries of the anterior surface of the vertebræ constantly reveals itself by pain and distress in the neighborhood of the spinal column. Many cases of sciatica or intercostal neuralgia will be found to be due to caries of the anterior surface of the vertebræ, and the diagnosis should not be made until a sudden increase of the symptoms, with some numbness and failure of power in the lower extremities or the appearance of an angular projection, calls attention to the real cause of the trouble. You will do well to be on your guard against the occurrence of this obscure lesion. Aneurism of the descending aorta is another condition to be excluded.

There is no tenderness along the spine, neither is there any projection of the vertebræ, and jumping does not cause pain. No pulsation, thrill or abnormal dulness can be detected. Caries of the spine and aneurism may therefore be excluded.

You observe that the pain is described as occurring in the right side and over the stomach; it is not markedly affected by eating, although radishes and some other vegetables make it worse, and it is worse when the stomach is empty than after an ordinary meal. It is associated with evidence of derangement of intestinal digestion, as shown by flatulence and irregular action of the bowels, sometimes constipation and sometimes transient attacks of diarrhœa. Having excluded the graver causes for this pain, we must conclude that it it is neuralgic and occupies the stomach, and therefore a form of gastralgia.

As to the cause of this; the family history is good, and he has good health until this affection developed. He does not use liquor or tobacco; he has not been overworked, but has gotten into the habit of eating his meals hurriedly. The gastralgia has probably been brought on by this rapid eating.

In the treatment of gastralgia the regulation of the diet is the chief element. The stomach is rarely able to receive and handle enough of food in three meals to support the system; consequently it is important that such patients should take more than three meals in the twenty-four hours.

Again the stomach is so hyperæsthetic and the mucous membrane so irritable that unless some digestible substance is in the stomach the acid juices are apt to excite pain, and hence the pain is more marked when the stomach is empty, and the ingestion of food affords relief; so that for this purpose, also, it is desirable to give food oftener than three times a day. Meals of smaller amount, and of extremely simple character, and at shorter intervals, is the rule for the nourishment of gastralgic patients.

The character of the food requires close very close attention. In general, it will be found that milk is one of the best ways in which to give nitrogenous and albuminoid food. The starchy foods are, as a rule, well borne, particulaly as they do not require much gastric digestion, being digested as you know, by the salivary, intestinal and pancreatic fluids. At times, however, the starchy foods lead to the development of secondary acids in the stomach, in which case it becomes necessary to diminish the amount of starch allowed and increase the amount of skim-milk, the patient being practically placed on an exclusive milk diet for a certain length of time. Alkalies are often desirable, and lime-water mixed with milk is a convenient way of administering these.

I shall recommend for this man the following dietary:

Breakfast.—Soft-boiled egg, oatmeal, bread and butter, and milk with lime-water. Between breakfast and dinner, a glass of milk and lime-water.

Dinner.—Potatoes, bread and butter, and milk and lime-water, but no meat. Between dinner and supper, a glass of milk and lime-water.

Supper.—Mush and milk with milk and lime-water to drink.

In selecting the remedies to be associated with this diet, you will be governed by your appreciation of the state of the mucous membrane more than by anything else. If there is no evidence of gastric catarrh, if there is simply the hyperæsthetic neuralgia and anæmic condition of the stomach, iron, arsenic and belladonna may be given at once with confidence, the stomach being sheathed with bismuth taken at proper interyals after eating. Under sueh circumstances, a pill containing the following might be given: ℞. Quiniæ sulph., gr. j.; acidi arseniosi, gr. $\frac{1}{50}$; pil. ferri carb., gr. j.; ext. belladonnæ, gr. $\frac{1}{50}$; M. et ft. pil. no. 1. Sig.—To be taken after food, three times a day.

Any of the vegetable salts of iron may be substituted for the pill of the carbonate. In addition to this, ten grains of bismuth should be given two hours later to protect the stomach when most empty.

If there be a catarrhal condition of the mucous membrane, as shown by a coated tounge, distress in the stomach, in addition to the paroxysmal pain and evidences of dyspeptic trouble, we are obliged to adapt our remedies to this condition, postponing the use of anti-neuralgic remedies until the inflammation of the mucous membrane is relieved. In such cases bismuth with pepsin, dilute mineral acids, carbolic acid, and salts of silver become exceedingly valuable for their antacid, sedative, and alternative properties.

For this patient, having directed a careful diet with alkali, we shall order minute doses of nitrate of silver with belladonna.

Two weeks later, the patient reported much improved, and the pill of quinine, arsenious acid, and iron above given was substituted for the nitrate of silver, the same diet being continued.

FOREIGN BODY IN THE PHARYNX.

Walter F. Atlee reports the following case in the *Med. Times:*

It is not at all an uncommon occurrence to have a visit from a patient who complains of having swallowed something that is still sticking in the throat. In almost every one of these cases there is no foreign body in the passage. Those patients have a local pain, in some cases the result of injury by a hard body hurriedly swallowed, and they are so entirely convinced by this sensation that a foreign body has lodged there that it is impossible to make them believe otherwise. The surgeon himself may make a mistake, and think he feels a something that ought not to be there. I heard even Nélation say that in a certain case, after pushing his finger deeply into the pharynx, and feeling a small resisting body, he made several attempts to seize it with the forceps before discovering it to be the great horn of the hyoid bone.*

I made observations somewhat similar to these to a man who came, in great excitement, on the evening of the 30th of last December, to take me to consult with a well-known and experienced physician in the northern part of the city in the case of a child in a dying condition from the presence in the throat of a pin, as the father protested, but which the doctor had not found and did not believe to be there. On the afternoon of Christmas-day, five days before, the father said his child, just seventeen months old, most certainly had a pin in her mouth, that it had disappeared when he went to take it out, and the symptoms of throat trouble began at that time. For five days the child had taken food with great difficulty and reluctance, keeping the hands in the mouth as if striving to pull something from the throat.

It will here be called to mind that while more bulky objects generally become arrested at the junction of the pharynx with the œsophagus, where the tube is narrowest and least easily expansible, a thin and pointed body, such as a pin, generally sticks between one of the pillars of the fauces and the tonsil, or thereabouts. Again, when such a body stops in the pharynx, that which takes place is owing less to its size than to its shape: it is a body that, as a rule, cannot be pushed farther instead of being extracted, as is often done with bodies of another kind. *It must always be extracted.*

On reaching the house, the child was found ly-

*See Clinical Lectures on Surgery, by M. Nélation, p. 54.

ing in a cradle, on her left side, the head thrown back, in a state of stupor, from which she could be roused but very imperfectly. She had had during the day several convulsions. The lips were bluish, and the whole countenance extremely pale, with a bluish tinge. There was a swelling in the neck on the right side, which was the uppermost, below the mastoid process, posterior to the line of the ear. This swelling was not so hard as in cases of diphtheria: it had the feel of cellular tissue affected by acute œdema and not by phlegmonous inflammation. In the mouth was some ropy mucus tinged with blood, but there was no repulsive odor. While examining these appearances it was suggested that the child had the mumps. There was no swelling, however, about the tempro-maxiliary articulation, nor anywhere anterior to the ear. It was posterior to the ear and inferior to the mastoid process. Moving the head, the left side of the neck presented a condition similar to that on the right, though not so marked.

The attending physician said his treatment had consisted mainly in the administration of the chlorate of potassa in a syrupy solution. He did not believe in their being any foreign body in the child's throat, but was very willing to have search again made for it. When searching for it himself, he had made use of his eyesight only, and had never passed his fingers into the pharynx.

The child was taken up and held in the nurse's lap in a convenient position for the examination of the pharynx. The doing of this roused her somewhat, so that a few drops of chloroform were used to quiet her. The mouth was then opened, and the jaws kept apart by a large cork. Then the finger was passed into the throat a pin was encountered, firmly fixed there, and seemingly stuck, one end between the right tonsil and the pillars of the fauces and the other in the posterior wall of the pharynx. The extremity of the forefinger of the left hand being kept in contact with the pin as a guide, a dressing forceps was made use of; and on the second attempt to seize it, and with the use of some force and some manœuvring to dislodge it, the pin was withdrawn. The pin was exactly an inch and three-sixteenths in length, and it was bent in the centre at an angle of about a hundred and twenty degrees. This bending could scarcely have been produced by the force used in extracting it from the throat.

As there was, of course, great difficulty, even impossibility, in making the movements of deglutition, and every attempt to swallow must excite reflex movements in the pharynx and retard cure, it was advised that no food or medicine should be given by the mouth. In order to try to nourish and stimulate the patient, appropriate enemata were ordered. The child, however, never revived, the stupor became more and more profound, and she died the following day,—just twenty-four hours after the removal of the pin. The cause of the trouble, the source of the irritation, having been gotten rid of, hopes were entertained that the patient might recover, but, as is often the case in children when the exhaustion and the enfeeblement of the nerve centres have been so great that repeated convulsions are the result, she never again became conscious, and life gradually went out.

The history of this case teaches nothing new, but it is well at times to be reminded of what may occur, and of the extreme care and watchfulness that are at all times demanded in the practice of our profession, in order to avoid sad and even fatal mistakes.

FRACTURE OF THE LOWER END OF THE RADIUS.

BY R. J. LEVIS, M.D., PHILADELPHIA.

The correct nature and mechanism of the ordinary form of fracture of the lower end of the radius is now, after much controversy, generally admitted and properly comprehended. With this proper understanding the indications of treatment become rational and decisive. In the usual and very characteristic fracture of the carpal end of the radius the primary line of the fracture is, with little tendency to deviation, *transverse* in direction. Associated lines of fracture are generally those of comminution of the lower fragment, and are caused by the upper fragment being driven vertically into it and splitting it, usually in directions towards its articular surface. The displacement of the lower fragment is towards the dorsal aspect of the forearm, and its articular surface is inclined in the same direction, abnormally presenting backwards and upwards.

The mechanism of the fracture is its production by falls upon the palm of the hand, which, with the carpus, undergoes extreme extension, and the fracture is caused by an *act of leverage* or *transverse strain*. This direction of force has also been called *cross-breaking strain*. In this fracture, actual displacement of the lower fragment may not exist at all, or it may be to the extent of complete separation from contact with the broken surfaces, varying with the amount of force applied and with the retaining influence of the surrounding dense structures.

The first essential of the treatment of fracture of the lower end of the radius is *the complete reduction of the displacement*. The action of replacement must be directed to the lower fragment itself. The reduction of the fracture can usually be thoroughly effected, under anæsthesia, by *strong extension applied to the hand, associated with forced flexion of the wrist, and with pressure applied directly on the dorsal surface of the lower fragment*. Unless vertical splitting or comminution of the lower fragment

exists, the maintaining of partial flexion of the wrist, with pressure of a pad on the dorsal surface of the fragment, will prevent return of deformity. With the object of retaining the apposition of the fractured surfaces, by overcoming displacing forces, I have practiced for many years on the principles involved in the splint here illustrated, the application of which will not require much description. In the treatment of fracture of the lower end of the radius it is essential that proper allowance be made for the curvature of the anterior or palmar surface of this part of the bone. This is insured in the splint which I have devised, which follows correctly the radial curvature; and the fixing of the thenar and hypothenar eminences of the hand in their moulded beds, maintains the splint immovably in its correct position with reference to the radial

curve. To neglect of complete primary reduction of the displacement of the lower fragment, and to inefficient restoration and retention of the normal radial curve, are due the frequent unfortunate sequences of this fracture.

The splint is made of copper, so as to be readily conformable by bending to suit the peculiarities of size and form of forearms. The slight roughness left on back of splint from perforations is for the purpose of keeping the bandage from slipping. It is nickel-plated to pervent oxidation. The splint will usually fit the forearm so accurately that but little padding will be required, and a piece of woven lint, or of cotton or woolen flannel is all that is necessary for its lining. No dorsal splint is needed, but, as before referred to, a small pad will, in most cases, be required over the dorsal surface of the lower fragment. For retention of the splint an ordinary bandage, two inches and a half to three inches wide, is all that is necessary. This splint has the merits of being applicable to all cases of fracture of the lower end of the radius, and also to many other injuries involving the forearm and wrist, and, as now supplied, is very inexpensive. It is manufactured by J. Ellwood Lee, 435 Walnut Street, Philadelphia, Pa.

ERRORS IN THE DIAGNOSIS OF PREGNANCY.—Professor Pajot, in a clinical lecture, observed that he wished to refer to a case which would prove of great value to the pupils, as putting them on their guard in relation to faults in the diagnosis of pregnancy. Such faults have been committed by men of the highest eminence, for if in 95 cases out of the 100 diagnosis is quite easy, in some others it is attended with extraordinary difficulty. In this case, of recent occurrence, such a fault had been committed by men in a high position, one of them enjoying great celebrity. In place of hesitating to communicate the case Professor Pajot brings it prominently forward, as it exhibits the precise rule which should be observed on these difficult occasions, and may save the reputation of the practitioner and even the life of the patient. A lady, thirty-five years of age, had a child when she was twenty, after a laborious labor requiring the forceps, and followed by a vesico-vaginal fistula. Since then she has had two labors, both quite easy. After the last of these, eight years ago, she suffered greatly from menorrhagia; but having five years since begun to introduce a large sponge into the vagina, for the purpose of sustaining the uterus, which had descended considerably, and absorbing the urine from the vesico-vaginal fistula, the menorrhagia ceased and was succeeded by irregular and sparing menstruation. Having become a widow she re-married, and coition was always performed with the sponge at the bottom of the vagina. Last summer she consulted Professor Pajot because her abdomen had greatly enlarged and she wished to know whether she was pregnant. Having removed the sponge he proceeded to examine her, and found the perineum very lax and easily depressed, a small vesico-vaginal fistula still existing. The cervix, in the erect posture, descended to within a few centimetres of the vulva, and was flattened, small, hard, atrophied and colorless. The orifice was but slightly developed. The uterus rose largely out of the pelvis and was very mobile, but its oscillations were not communicated to the cervix. Professor Pajot delayed giving his opinion on the case for a fortnight, when the patient declared that she felt the child move; but the fœtal heart could not be heard and the opinion was still withheld. Meanwhile an accoucheur and hospital surgeon was consulted, who, after an atten-

tive examination, declared that an ovarian cyst existed. This alarming the patient, a celebrated laparotomist was consulted, who stated that a large fibrous tumor of the uterus existed and advised an operation. Three weeks after this last consultation, the patient having taken some very violent purgatives, gave birth to a child between seven and eight months old, all traces of the tumor disappearing. "Faults like these are committed only because old counsels which I have long since delivered have been forgotten. In these difficult and obscure cases, I said there is a simple line of conduct to be followed, which is both useful and prudent, and never compromises the health or life of the patient nor the reputation of the practitioner. This is *expectation;* we must know how to wait. If there is some pressing indication, of course we must fulfil it; for, when life is menaced, what matter is it about the pregnancy? But, as a general rule, neither the health nor the life of the patient is in question. The woman desires to know whether she is or is not pregnant. And as long as the problem does not appear to be soluble with certainty we should make no resolutions. Let us wait, and above all things wait without acting, if nothing creates an absolute necessity for action. Time is the best of all our means of diagnosis."—*Press Med. Belge*, Sept. 7, 1884; *Med. Times.*

FEVERS—GENERAL TREATMENT.—Professor Da Costa gives the following general rules for the treatment of fevers:

1. Reduce the temperature. The cold bath will do this most rapidly and certainly, but it is troublesome, and not altogether free from danger, and should therefore only be used as a last resort. Quinine in full doses is safer, and may usually be relied upon. It should not, however, be repeated too often, as it may produce alarming cerebral symptoms, with diarrhœa and general perturbation.

2. Lessen the rapidity of the circulation. Aconite is the best remedy here, especially if the pulse is full and frequent, but if the circulation is weak, digitalis will act better. Professor Da Costa does not, however, often give either. He prefers to endeavor to reduce the temperature, and so indirectly to control the circulation.

3. Keep up the secretions. Remove the waste of the tissues by diuretics, diaphoretics, and laxatives.

4. Nourish the patient. "Don't starve a fever." Give milk, beef juice, and other light nutritious food in small quantities, but at frequent intervals. Give the patient plenty of fluids also. Slightly acidulated drinks will be found to be both grateful and beneficial.

Professor Da Costa's experience has been that typhoid-fever patients do better, as a rule, on the dilute nitro-muriatic-acid treatment than on any other of the many that have been proposed. It controls the diarrhœa to some extent and aids digestion. He generally orders twenty drops of it to be taken every four hours in water or syrup. The circulation is to be sustained at the same time, and the heart's action steadied by the administration of quinine in tonic doses—gr. vi-x daily; or, better still, by alcohol in small and frequently repeated doses. If the discharges from the bowels exceed three a day, or if they are excessive in quantity, they must be lessened by opium or opium and bismuth; or if the stomach be irritable, by opium and carbolic acid, or carbolic acid and bismuth. If these remedies prove unavailing, a combination of nitrate of silver or sulphate of copper with opium will usually be found effective.

For the tympanites, Professor Da Costa recommends cold-water applications to the abdomen, injections of vinegar and water, or turpentine stupes externally, combined with the internal administration of ol. terebinthinæ gtt. v-x and morphiæ sulph., gr. ⅓ every two or three hours. The latter plan will be especially valuable if the tympanites co-exist with a dry, glazed and fissured tongue. The very high temperature that sometimes develops can be most safely and efficiently lowered by either the cold bath or by ice-water cloths on the abdomen.

The other complications are to be treated as they arise.—*Med. Bulletin*, January.

COMPLETE ASPIRATION.—David Christie, L. R. C. P. Ed., etc., Medical Officer of Rossguill Dispensary, writes:—

For some years past there has been much written regarding the use of the aspirator in cases of pleuritic effusion, and the talent displayed on this subject is creditable to the medical profession; but in using the aspirator there has been one thing ommitted that mars or nearly destroys its utility. I have waited more than two years for some one to find it out, but, strange to say, in vain.

The thing is as simple as making an egg stand on its end *when you know it*, and the only mystery about it is that no one seems to have thought of it. I have tried partial aspiration as it is usually performed, and find that the pleural cavity refills in a short time; after complete aspiration it does not. The way it is managed is very safe and simple. I put a broad bandage round the chest that can be laced behind like a corset; then as I pump the fluid *out*, I press the ribs *in* by tightening the bandage. I think when I do so it is unnecessary for me to explain that I prevent any internal organ from being displaced (at the same time keeping them at a proper pressure), and the ribs by their elasticity from acting as a suction pump to cause a re-accumulation of fluid. I allow the bandage to remain on for some days. Any one who understands the action of a pump and a

syphon requires no further explanation. Many imagine they do, but are mistaken; these I would advise to consult "Ganot's Physics." After a certain amount of fluid has escaped, dragging pains set in. Tightening the bandage instantly gives relief. Alternate aspirating and lacing should be continued until all is removed; then there is likely to be a fit of spasmodic coughing; the patient may spit some frothy mucus tinged with blood, but all such symptoms pass off in a few minutes, and do not return—at least, that has been my experience.

I may add that the needle should be put in at such an angle that, after piercing the costal pleura, the point can be made to touch it again, so that when the pleuræ approach each other the lung may not be wounded; and when necessary the pleural cavity should be made antiseptically clean. *Med. Press*, Jan. 28th.

TREATMENT OF BRONCHITIS—WOOD.—It is not generally known that alkalies in large doses are amongst the most efficient of sedative expectorants. The citrate of potassium is much the most eligible for administering alkaline expectorants; of it half to one ounce should be given in 14 hours. The following prescription has been tested during four to five years, and found to be much the most reliable and sedative cough mixture that I have ever used:—℞. Citrate of potash, one ounce; lemon-juice, two ounces; syrup of ipecac, half ounce; syrup enough for six ounces. Dose—Tablespoonful four to six times a day. When there is a good deal of cough or any excessive susceptibility of the bowels to loosening medicine, paregoric should be added in small quantity. The ipecac should be varied according to the susceptibility of the patient's stomach. Sometimes it can be advantageously substituted by tartar emetic. Usually two to three days of such medication will establish free expectoration. Then the stimulant expectorants are required, or squills and seneca, the former being the more valuable, though I cannot affirm that I have obtained positive results from their use, and think much of their reputation is based upon tradition and natural tendency of the disease to subside. Even squills is inferior to the mur. of ammonia. Like all ammoniacal preparations, this must be given at short intervals to maintain constancy of effect. The action of the single dose can scarcely last over two hours. Its acridity and disagreeableness may be somewhat covered by glycerine. In very large amounts all ammonia salts are capable of acting on the crasis of the blood as alkalies, and causing great vital depression. The value of copaiba in chronic bronchitis has been long recognized, and it may sometimes be used with advantage in obstinate subacute bronchitis. When the "cold" in children is obstinate, "syrup of garlic" is very efficacious. But the stimulant expectorant which in my hands has almost replaced others of the class is the oil of eucalyptus. It may be administered in ordinary cases of adults to the amount of about forty minims a day. Its taste is so pre-eminently disagreeable that it should be given in capsules, each of which may contain ten minims; or, if the patient prefer, two capsules of five minims each may be taken at a dose. The oil appears to be slowly absorbed and eliminated, so that four times a day is often enough. In emulsion it is very apt to cause unpleasant eructations, but in capsules is usually well borne. Some stomachs will not tolerate it. Counter-irritation is very useful; the oil of amber, an old remedy, is especially valuable in young children who have so often marked nervous disturbances and a tendency to collapse, diluted with one to three parts of sweet oil, applied to chest upon saturated flannel; it sometimes acts very happily in allaying nervousness as well as internal congestion.—*Ther. Gaz.*

VACUOLATION OF THE BRAIN.—Dr. J. C. Shaw read a paper before the New York Neurological Society, Feb. 3, 1885, on this subject, and showed a specimen.

Dr. Peters stated that very interesting cases were to be found on record in the "Transactions of the Pathological Society of London."

Dr. Parsons had never seen vacuoles of the brain of the size of those shown in the specimen. He had seen smaller ones. His impression was in accordance with the views expressed in the paper with regard to the origin of the enlargement of these perivascular spaces.

Dr. Weber thought that the vacuoles in this brain might be connected with septic fever, which certainly must have taken place during the man's life. He was inclined to think that there might have been infarctions in the brain which might have something to do with such immense vacuoles. He wished to know if Dr. Shaw had examined the brain soon after death.

Dr. Shaw said that he had done so the next day. He had cut into the brain afterward and found these cavities. There was nothing on the outer surface of the brain to indicate them.

Dr. Weber asked if Dr. Shaw really believed the larger-sized ones to be real vacuoles.

Dr. Shaw said that he really did.

Dr. Weber then asked if vacuoles as large as these had ever before been seen by Dr. Shaw or by any one.

Dr. Shaw stated that no one had seen them so large. He had not, at all events. The largest he had ever seen were of the size of a small nut.

Dr. Weber stated that the largest he had ever seen were as large as a pea, drawn out. They were of the size of the smaller ones surrounding the large ones in the brain that had been shown. In this respect he considered the specimen unique.

Dr. Shaw said that the reason he had presented

it was because it was an extraordinary specimen; a great many cases were reported where there were no vacuoles. This man had certainly been subject to septic trouble. Dr. Shaw asked if those cyst cavities were not due to hæmorrhage.

Dr. Weber thought that the man probably had septic pleurisy. There might have been emboli carried into the brain; certainly there was septic matter coursing through the arteries. In the cases he had known of there had been no structural disease going on.

It had struck Dr. Shaw that possibly thrombosis might have taken place in some of the small vacuoles, and that a large number of them might have been blocked up in that manner. The explanation that the perivascular spaces had been dilated was not a very good explanation for cavities of such large size.—*N. Y. Med. Journal.*

ADDISON'S DISEASE.—The details of the post-mortem and the microscopical appearances in a case of Addison's disease are given by Professor Cacciola, of Padua. (*London Med. Record*, Jan 15, 1885.) The patient, a man-servant, thirty-five years of age, died a year and a half after the skin had begun to bronze. The discoloration, with muscular weakness, had steadily increased. Febrile attacks occurred from time to time, and the patient died in one, delirious and convulsed. After death, beyond a certain softness of the brain, the nervous system, including the brain, the spinal cord, and sympathetic nerve, was found absolutely normal. The semilunar ganglia and solar plexus especially were carefully examined. The suprarenal capsules, on the contrary, were greatly altered. They were enveloped in a mass of fat and fibrous tissue, closely adherent to them. Each capsule was about the size and shape of a hen's egg, and weighed about thirty-five grammes. On section, the organs were seen to consist of a thick fibrous capsule of lardaceous appearance and tendinous consistence, sending prolongations inward. Between these prolongations were caseous substance and calcareous masses. The fibrous capsule and septa consisted of a thick connective tissue, with accumulations of leucocytes in course of degeneration. The contents of the spaces between the septa were made up of albuminoid detritus and oil-globules. In the central portion of the fibrous mass the connective tissue was calcified. Schizomycetes were looked for without success, but it is especially mentioned that some fat globules looked like Koch's bacilli colored by Weigert's method. There was little noteworthy amongst the other pathological conditions. There was, however, engorgement of the lymphatic follicles and of the agminated glands of the intestinal mucous membrane. The kidneys also were enlarged —*Boston Med. Journal.*

CAFFEINE AS A SUBSTITUTE FOR DIGITALIS.—Dr. J. Stewart, in *Can. Med. and Surg. Journal*, says: In the form of a double salt, as natrobenzoate, its action may be summed up as follows:

1. It strengthens, slows and steadies a weak fast, and irregular heart.

2. It quickly acts as a diuretic in cardiac dropsy, owing to its power of (*a*) raising the blood-pressure, and (*b*) of stimulating the secreting structures of the kidneys.

3. It is of marked use in the same class of cases as digitalis is. It differs, however, from that drug, in the following particulars: (*a*) It is less powerful as a cardiac tonic; (*b*) it is a more powerful and prompt diuretic, and for this reason it gives relief quicker from all the troublesome subjective symptoms of cardiac failuse.

It is probable that results obtainable from neither of these drugs, when given singly, could be brought about if caffeine was given first and its effects kept up until the cumulative action of digitalis could be made manifest. By combining the power of digitalis with the rapidity of action of caffeine we may get the advantages of both drugs with little of the disadvantages of either. There is no published evidence relating to these points, however.

Dose and mode of administration of Caffeine. The dose of any of the double salts should not exceed thirty grains in the twenty-four hours, this quantity being equal to about twenty grains of the pure alkaloid. Usually half the above dose will answer all purposes. The double salts are prepared by Merck, of Darmstadt, but have not as yet found their way to this side of the Atlantic. They, however, can be prepared extemporaneously. The following formula contains in each tablespoonful about one gram (fifteen grains) of caffeine:

Caffeine..... 15.00 (gr. 230);
Benzoate of Soda.... 15.00 (gr. 230):
Water.....250.00 (℥viij).

The doses of caffeine (two or three grains) usually ordered are quite inadequate to act either as diuretics or cardiac tonics.

SO-CALLED SPECIFIC TREATMENT OF TYPHOID FEVER.—Dr. J. W. Hawkins, *Kansas City Medical Record*, Feby, 1885, says: It is said by medical writers of the present day that there is no known specific treatment for typhoid fever. We are gravely told that "the abortive plan by the use of calomel is the only treatment that can be considered ætiological or casual." To this statement I respectfully demur. If calomel aborts the fever in fifteen to twenty days, the bromide-of-potassium treatment will do it in seven to ten days. The bromide of potassium is a medicine (unlike calomel) attended by no bad results, and upon it we can confidently rely. It may be given in any and all stages of the fever—first, second, third, fourth,

fifth or sixth week. If you see the patient on the first or last day of the fever, begin at once to administer the antidote—bromide of potassium. In the whole metasyncritic cycle of remedies for typhoid fever the bromide of potassium stands at the head. It accomplishes what no other known remedy has done, when properly administered. It usually arrests the fever in from seven to ten days after beginning its use. If the treatment is commenced at the beginning of the attack, five-grain doses administered every three hours during the day only, and repeated daily, will usually be sufficient. But if in the last stage, from fifteen to forty grains will sometimes be required. In the last stage of a very severe case, when death seemed almost inevitable, I gave more than two hundred grains in twenty-four hours, producing no gastric disturbance whatever. The patient recovered. Hence from this and other like cases I am led to believe that we have a specific for enteric fever.

The truth of this has since been verified in the treatment of ten additional cases, the fever in every case being arrested in from seven to ten days. I think I am not talking too forcibly when I say that bromide of potassium is as much a specific for typhoid fever as the sulphate of quinia is for (ague) intermittent fever.

How to see one's own retinal vessels.—Dr. Maher, of Sydney (*Australasian Med. Gazette*, Nov. '84), describes a new method by which this may be accomplished.

Standing a short distance (ten or twenty feet) from a light gas jet, in a dark room, and covering one eye, say the left, with the left hand, the observer takes between the forefinger and thumb of the right a strong convex lens, and holds it at about its focal distance in front of the right eye. Then, steadily gazing at the light through the centre of the lens, he shakes the lens rapidly backward and forward along its axis, or up and down or from side to side. After a few seconds the shadow of the fovea centralis appears in the axis of vision as a light yellow patch studded with dark coarse granules. Simultaneously the retinal vessels in the region of the yellow spot, including the finest capillaries, appear as dark cords against the yellow light. This appearance according to Dr. Maher, is not unlike plate 72 in the last edition of Nettleship's book on "Diseases of the Eye," except that the difference between the arteries and veins is not so marked, and that one gets a more extensive view, seeing the shadow of the retinal vessels as far as the optic disk. The outline of the shadow of the fovea centralis, which falls upon the most sensitive part of the retina, the yellow spot, is well defined, while the outline of the shadow of the optic disk cannot be distinctly seen, as it falls upon a much less sensitive part of the fundus. The shorter and more rapid the movements of the lens, the sooner the shadows of the retinal vessels and fovea centralis appear, and the more distinctly are they seen.

Dr. Maher claims that this is a simple and easy way of demonstrating:

First.—That there are no blood-vessels in the fovea centralis.

Second.—That the structures in which the visual impulses originate must be behind the retinal vessels.

Third.—That the fovea centralis differs in structure from the other parts of the retina.—*Med. Record.*

Phlegmasia Dolens.—It appears that notwithstanding the numerous works and discussions on plegmasia alba dolens the subject has not yet been exhausted. Dr. Brun, of Paris, has just written a work on the subject which throws some new light on its symptomatology. He considers the disease under two forms. The first occurring as a malignant affection from the onset, and causing speedy death; the second appearing as incidental in the course of a general pathological condition. The first, or infectious form, has been well known since the time of Velpeau. The second form the author sub-divides into latent, common, and lymphangitic. The latent form comprises those cases of sudden death from dyspnœa in severe diseases and after childbirth, in which the autopsy shows venous thrombosis of the limb, from which the detached particles have been carried into the circulation and obstructed the pulmonary artery. The common form is passed over as it has been so often described. The lymphangitic form is described as presenting a bright rosy color, diffused pains, which disappear slowly, great increase in the temperature of the limb and long-persisting œdema. The complications are: periphlebitis, consecutive arteritis, gangrene, and especially pulmonary emboli. The author regards a pre-existing lesion of the vein as the pathogenic cause. It may be due to vitiated nutrition, cachexia, or some severe febrile condition. A part of his observations, however, show that the nervous system deserves a share of attention. The views advanced by other recent writers on this disease are also of interest. Dr. Esler reports in the *British Medical Journal*, September, 1884, two cases of phlegmasia dolens occurring on the right side of patients who had, during and after labor, lain continuously on the right side. Dr. Dill, of Belfast, believes that one position long maintained may have something to do with the affection, but holds that the wearing down of the system from hemorrhage and irritation of the womb often induces it. Dr. Macartney relates in the *Indian Medical Gazette*, of November, 1884, the case of a young soldier, who, after suffering pain in the iliac fossa with obstinate constipation for ten days, during which time his temperature rose regularly

each evening, suddenly experienced a severe pain in the left groin and the limb began to swell, reaching nearly twice the size of the normal leg. The pain was excruciating and not relieved by hypoder mics of morphia. The s velling was uniform, el stic, but not pitting on pressure, there was œdema about the ankle. After four days improvement began, but was very slow, the limb being powerless, and attempts to move it causing dull aching pain. The author regards the case as one of phlegmasia dolens differing in no essential point from the disease as it occurs in lying-in women. The obstinate constipation, with pain in the left iliac fossa appears to have been the exciting cause, just as pressure of the fœtal head in this region, followed by pain and malaise, is believed to produce the disease in puerperal woman. Another case is mentioned as having occurred in the same hospital a short time before, in a man recovering from enteric fever.—*Med. Record.*

PÔRTABLE ANTISEPTICS.—Dr. T. E. Hayward. of Haydock, writes: Professsor Lister has recently recommended as a portable antiseptic, a saturated solution of corrosive sublimate in glycerine; a fluid drachm of this solution being sufficient to convert about four pints of water into one in a hundred solution. The glycerine solution, doubtless, occupies a comparatively small bulk, and is readily mixed with water; but it is not very convenient to manipulate in measuring small quantities, and, if the bottle containing it should be broken, or become uncorked while being carried with other things, the result is unpleasant. A much more handy way of carrying the corrosive sublimate is to prepare powders, each containing ten grains of the salt and chloride of ammonium. One of these mixtures will dissolve in a little water in a few seconds; and, on diluting up to a pint, a solution is ob tained of the strength of one to nine hundred and sixty. A few of these powders, wrapped round with gutta percha tissue to avoid deliquescence, can readily be carried in the pocket-case. The well known fact that ammonium chloride aids the solution of corrosive sublimate in water, renders the above suggestion so obvious that it has, doubtless, occurred to many; and it has probably already appeared in print. In view, however, of the very great advantage to all surgeons in country practice of having so ready a means of preparing an antiseptic solution, it may be pardoned if attention is drawn to the matter.—*British Med. Jour.*, Oct. 18, 1884.

PHOSPHATIC CONCRETION OF THE BOWEL.—Some weeks ago a young girl of about 18 years presented herself at Prof. Pancoast's clinic, with an opening in the abdominal walls on the right side, at a point near the middle of a line drawn from the umbilicus to the anterior superior spinous process of the ileum. The history of the case developed the fact that the wound was the result of an injury received some four years ago, and that during this time more or less pus had been discharged through the sinus. The patient having been anæsthetized and the wound slightly enlarged, it was found that the finger could be carried directly into the peritoneal cavity. This was rather an unexpected disclosure, and so antisepsis had not been provided for. Prof. Pancoast found upon a coil of small intestine a hard mass, which, upon removal and examination, proved to be a phosphatic concretion. The intestine was brought up to the mouth of the wound, a few bleeding orifices were secured by some fine black silk ligatures, and after all hemorrhage had ceased, the opening was dressed. The patient bore the operation remarkably well; on the second day a localized peritonitis set in, but this was soon controlled. The wound began to heal rapidly, except at its most dependent part. This occasioned the reopening of the parts, and another similar concretion was removed. From this time on the young woman did exceedingly well, the wound healing kindly, and before her discharge from the hospital she was presented to the class, apparently looking none the worse for the operation and her consequent protracted stay in the hospital.—*Col. & Clin Record.*

TRACHEOTOMY WITHOUT A TUBE.—The danger and inconvenience connected with the tracheotomy-tube *per se*, are sufficiently great to have aroused a desire for some device which would obviate them. The matter was the subject of discussion before a late meeting of the Philadelphia Academy of Medicine. Dr. J. B. Roberts said he had had so much difficulty in keeping the tube clear that he had discarded it entirely, and instead cut out a rectangular piece of the trachea and stitched the edge of the opening to the skin. He found this to answer better than the double canula which is liable to become choked with the secretion. Dr. Packard had operated in this manner, but feared to adopt it as a general rule lest constriction of the trachea occur through cicatrization of the opening on healing. He instanced one case in which this had occurred. He thought the testimony in favor of tracheotomy without a tube was, however, very strong. Dr. J. H. Brinton recalled two cases in which the tube had been dispensed with. The membrane was readily ejected, and there was far less trouble than from the tube. Both cases, however, died from diphtheritic infection. Dr. Nancrede regarded the danger from ulceration from the irritation of the tube as sufficiently great to warrant the adoption of such a substitute for it as had been suggested, and the sentiment of the meeting was in favor of according a trial to the method of performing tracheotomy

which should dispense with the canula.—*Med. Age*, Jan. 10th.—*Analectic.*

ACUTE BRIGHT'S DISEASE.—In Professor A. L. Loomis recent treatise on "Practical Medicine," the author reviews the subject of treatment by diaphoretics and hydragogue cathartics. He states that he has been convinced for some years that the depurative method was wrong, and gives as the three indications: the elimination of urea and its allies, the removal of inflammatory products from the tubules, and the counteraction of the effect of urea and its waste products upon the nervous system. For this purpose the patient is put to bed, frequent dry cups are applied over the loins, and infusion of digitalis is given internally. This may be supplemented with acetate of potassium, spirits of nitrous ether, or some other mild diuretic. The bowels are of course kept open, and the skin moist. If severe uræmic symptoms appear, hydragogue cathartics and hot-air baths may be temporarily resorted to. Milk should be the only article of diet, and water is the best diuretic.

The view taken as to the utility of digitalis and the potash salts in nephritis, is sustained by the clinical experience of nearly all English observers from the time of Bright.—*N. Y. Med. Record*, January 3rd.

LANCING CHILDREN'S GUMS.—In the discussion of this subject before the Medical Society of London, Mr. Hamilton Cartwright (dentist) was distinctly of opinion that both diarrhœa and convulsions might be caused by dentition. There were two conditions under which lancing the gums is indicated: 1. If the gum is tense and glistening at the epoch when the tooth is about to come forward, by cutting into the sac of the tooth great and immediate relief is afforded. 2. In an inflammatory condition of the gums with tumidity, but without the extreme tension of the first class of cases, incision gives relief. In the latter class of cases the treatment is empirical but none the less successful.

Dr. C. J. Hare said it was to him a matter of great surprise and regret that the profession should so blindly give way to fashion as it had done on many points. Hundreds of lives had been lost by abandoning the use of bleeding; and among the forms of bleeding, the practice of lancing the gums, that is, bleeding from the gums, is one that deserves to be revived or continued. Dr. Webb had seen so many children on the point of death saved by lancing the gums that he regards it as a most valuable method of treatment.—*Md. Med. Jour.*, Jan. 31st.

HINTS ON THE USE OF DRAINAGE TUBES.—In the *Journal of the American Medical Association*, Jan. 3rd, 1885, Dr. H. L. Getz, of Marshalltown, Iowa says:—"Some months ago we had occasion to evacuate a pelvic abscess, and use a drainage tube for through drainage. Not having at hand at the time a regular drainage tube, we constructed one out of a piece of plain (small size) rubber tubing. After being in the opening for several days, we desired to replace it by another tube; we attempted to remove it; but found that the openings in the tissues through which the tube had passed, had contracted so as to hold tightly the tube, and although we made but slight traction, anticipating the possibility of the tube's breaking, to our extreme discomfort and dissatisfaction we soon realized that our anticipations were realities, a portion of the tube, an inch in length, remaining within the pelvic cavity.

We succeeded in removing it by dilating the opening through which the tube passed; then introducing a small blunt hook, we succeeded in drawing the piece of tube into position, so that it was easily grasped by a pair of forceps and extracted, much to our satisfaction, and with a vow that in the future we shall *select with caution our material for drainage tubes.*

A hint on the removal of tubes, and also upon their introduction, may not be out of place here; under circumstances as above described where the tissues firmly hold the tube, we should adopt the plan of inserting within the tube a dilator of some kind, with which to dilate the tissues before we attempt to withdraw the tube.

As a satisfactory method of introducing drainage tubes, we have found that where a trocar-canula was necessary to evacuate the contents of a cyst or an abscess, by taking the precaution to use a canula a trifle larger than the drainage tube to be used, the latter could be conveniently passed through the canula to position, and then the canula withdrawn.

PARALYSIS FOLLOWING HYPODERMIC INJECTIONS OF ETHER.—Arnozan ("Gaz. hebd. de méd. de chir.") contributes a long article on this subject, in which he cites a number of interesting cases. In several instances in which injections were made under the skin of the posterior aspect of the forearm, paralysis of the extensors was noted within a few minutes. Under the use of the constant current the condition eventually disappeared. In one case a deep injection into the thigh was immediately followed by darting pains, which persisted for two weeks. The leg became livid, and wasted away, and the reaction of degeneration was observed. The patient subsequently developed a trophic ulcer on the heel, and improved very slowly, though under treatment for a year. The writer thinks that the phenomena described are really symptomatic of neuritis, which is due to the irritating action of the ether that has been deposited in the neighborhood of the nerve. [It is to be hoped that the publication of these will lead to more caution in those who are accus-

tomed to resort freely to hypodermic injections of ether, brandy, and even ammonia, in cases of collapse.] Ed.

TREATMENT OF NASAL POLYPI.—Dr. Richardson, in the Asclepiad, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. The cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient can expel the whole mass of destroyed polypus in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol ; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Weekly Medical Review*, February 28, 1885.

LAPAROTOMY FOR GUN-SHOT WOUND.—The first successful case of laparotomy for gun-shot wound done in this country, and the second on record, is reported in the *New York Med. Journal*, of Feb. 14, by Dr. W. T. Bull. A man shot in the abdomen by a bullet from a revolver (caliber No. 32), was admitted into the Chambers St. Hospital, New York, where, twelve hours after the accident, Dr. Bull saw him. The wound was situated at a point an inch and a half below the navel, and an inch and a half to the left of the median line. Seventeen hours after, having convinced himself by probing the wound that the bullet had entered the abdomen, Dr. Bull made a median incision through the abdominal wall. The gut presented, and on careful examination seven perforations were found. These were all closed with silk sutures. The search was continued, and the bullet was at last found lodged in the wall of the sigmoid flexure. The wound in the abdomen was closed after the cavity had been thoroughly cleansed with a solution of carbolic acid (two and a half per cent). As a preliminary to the operation carbolic acid by means of the spray was diffused through the room, in which was maintained a temperature of 80° F. All solutions were used warm.—*Med. Review.*

EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.—Dr. Guttierez reports this curious case in *El Diceamen* (*Le Progrès Medical*). A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a fœtal head. Capillary puncture gave a clear fluid containing numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally the skin, using Lister's dressings. There was not the slightest trace of peritonitis, the reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal. —*Jour. Am. Med. Association.*

IODOFORM IN THE TREATMENT OF COMPOUND FRACTURES.—Bach (Inaug.-Diss, "Centralbl. f. Chir.") speaks highly of the direct application of powdered iodoform to open fractures. The powder is sprinkled upon salicylic cotton, and placed over the wound. Over this is applied a quantity of iodoform gauze, and the whole is secured with a plaster-of-Paris bandage. Of twenty-eight cases which were thus treated, sixteen ended in perfect recovery. The bandages were not disturbed during the entire process of healing. In another series of twenty cases, twelve were cured. The writer arrives at the conclusion that the treatment with "iodoform-scabbing" (*Iodoformschorftherapie*) without drainage, is to be recommended in all cases of compound fracture in which the laceration of the soft parts is not too extensive. A neglected wound, in which there are numerous pockets filled with pus, is a contra-indication to this method of procedure—*N. Y. Med. Journal.*

ERGOT AS A MEANS OF DIAGNOSIS.—Dr. J. W. Elliott in reporting five cases of ovariotomy in the *Boston Medical and Surgical Journal*, January 29, notes a use of ergot, which seems original with him. There was a very large immovable tumor, larger than a hen's egg, in the hollow of the sacrum somewhat to the right side. The uterus was three and a half inches deep and in left lateral retroversion. The tumor and uterus seemed blended into one mass. It was very difficult to determine what the tumor was and to what it was attached. To assist in determining this point Dr. Elliott administered ergotin pills until the uterus became fully and firmly contracted, when he found

that organ harder than the tumor and of decidedly different consistency, from which he was led to conclude that the tumor was not growing from the uterus, but only crowded against it.—*Med. Review.*

FOLLICULAR PHARYNGITIS.—E. S. Billings, M.D., writes: Will you please inform me through the columns of *The Monthly* what I shall do for an old case of follicular pharyngitis? It is one of the most obstinate cases I have ever dealt with, and I have exhausted all the means I know of, and oblige.

[Wipe the diseased surfaces well with a solution of bicarbonate of soda, three drachms to the ounce of water. After this is thoroughly done, removing all the secrections, spray it well with a solution of nitrate of silver, from twenty to forty grains to the ounce of water. This should be repeated once or twice a week as the indications call for. As a rule we have no trouble in curing the cases we have met with in this manner.—ED]—*New Eng. Med. Mo.*, Jan.

CARBONATE OF AMMONIA IN SCARLET FEVER. Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*Med. Record.*

PIN SWALLOWING.—In the New York *Medical Record* of Jan. 15th, 1885, I noticed an article on "Pin Swallowing." I paid very little attention to it, as the case was treated contrary to my teachings. On Feb. 2nd, about 4.30 p.m., Mr. G. H. E., came to my office in a great hurry and stated that his daughter Nettie, about 8 years old, had swallowed a large shawl pin. She placed the pin in her mouth to arrange the shawl around the shoulders, and while doing this threw back her head and down went the pin. I told him I was taught to give a brisk cathartic in such cases, but I believed it better to give plenty of bulky food, as I had read an article to that effect not long ago in some journal. He told me the child lived almost exclusively on bread, of which she ate enormously. I advised him to give plenty of food, no purgatives, and watch the stools. The pin was swallowed February 2nd, 4 p.m.; evacuated in the centre of a mass of fæces February 4th, 2 p.m., forty-six hours afterward. It measured 2⅛ inches in length, with very sharp point, and a glass head somewhat larger than a buckshot. It passed away as it entered the mouth, head first.—*Dr. Wagner, in Col. & Clin. Record*

DANGER OF DIPHTHERIA CONTAGION.—Prof. Jacobi, (New York *Med. Journal*) says that many sore throats regarded as trivial are, in point of fact, diphtheria; especially those known as follicular tonsillitis. What to-day looks like one or more points covering the outlet of ducts, to-morrow may be a continuous membrane. Some mild cases of diphtheria are prolific of danger because they are apt to assume a chronic course without losing contagiousness. The throats of servants, nurses, and others who are in constant contact with the children of a household or school, should be from time to time inspected. There is as much diphtheria out of bed as in it; nearly as much out of doors as in-doors. Diphtheria is contagious, and probably has no spontaneous origin.

INJECTIONS OF ETHER AND IODOFORM IN COLD ABSCESS.—Professor Verneuil obtains a rapid cure in almost all his cases of cold abscess, abscess from diseased bone or from congestion, etc., by ethereal injections of iodoform of the strength of one in twenty. The abscess is first emptied by means of Potain's aspirator, and then receives from 100 to 300 grammes of the iodoform solution. By not exceeding this quantity (*i.e.*, five to fifteen grammes of iodoform) no fear of accidents need be felt. The liquid penetrates into all the anfractuosities and diverticula of the abscess, the ether becoming absorbed or evaporated, and the antiseptic agent being deposited uniformly on the pyogenic membrane, the action of which it modifies. This simple means, so exempt from danger and for ease of applications has proved highly successful, very large abscesses having yielded to three or four injections.—*Revue de Thérapeutique*, August 15, 1884.

SAVE THE FINGERS.—Dr. William D. Ronaldson of Philadelphia, writing to us on the subject of conservative surgery, reports two cases which show it is often better not to yield to the impulse to cut off a bad-looking finger. A. B., a brakeman on a railroad train, had his finger caught between the bumpers of the cars while endeavoring to couple them. The nail and flesh were torn completely off, leaving the distal extremity of the bone exposed. The injury was of such a nature that amputation of the ungual phalanx would have been permissible; but having cleansed the wound thoroughly with tepid water, a dressing of carbolized oil (1 to 15) and cosmoline was applied. The finger healed in three weeks, and, except for the loss of the nail,

was as serviceable as before. The second case was similar to this one, in treatment and results.—*Medical Record, Feb. 14th, 1885.*

IDIOPATHIC ANÆMIA.—A favorite prescription of Prof. DaCosta in marked idiopathic anæmia is:

℞ Ferri sulph ..... ʒ j.
Potassii carb. ..... ʒ j. M.
Ft. pil. No. xl.

SIG.—One after meals for first week; increase dose in second week, etc.

If the patient is a female suspend treatment during menstruation.—*Col. and Clinical Record*, January.

ALCOHOL IN THE TREATMENT OF INSANITY.—Dr. W. B. Fletcher, Superintendent of the Indiana Hospital for the Insane, and Dr. R. M. Bucke, of the London, Ontario, Asylum have entirely abandoned the use of alcohol in any form in the treatment of the insane. They believe that their patients do just as well as before, and perhaps better.—*Med. Record.*

HIMROD'S ASTHMA CURE.—Dr. A. J. Campbell writes in the *Brit. Med. Journal*: "In Martindale's *Extra Pharmacopœia* there is an excellent substitute for Himrod's asthma cure, which I have tried and found very useful. Dissolve two ounces of nitrate of potassium in two ounces each of lobelia, stramonium leaves, and black tea well powdered; mix well and dry thoroughly. A tea spoonful burned, and the fumes inhaled, generally gives immediate relief."

AN APPLICATION FOR OZŒNA.—The followihg is Vidal's formula, as employed at the Hôpital St. Louis ("Jour. de med. et de chir. prat."; "Practitioner"):

Solution of chloride of zinc, 5 per cent...1 ounce:
Boric acid.....14 grains;
Water.....28 ounces;
Ammonia-water, enough to neutralize the solution.

FORMULÆ.—Prof. Bartholow has frequently prescribed the oil of wintergreen in rheumatism, with excellent results. A useful combination is:

℞ Ol. gaultheriæ.. ....ʒ j
Acidi salicylici..... ....ʒ iv
Sodii biborat... .....ʒ j
Syrup. picis liquidæ,
Aquæ anisi.....*aa* f ʒ ij M.

Sig.—Dessertspoonful every four hours.

In chronic bronchitis with asthmatic breathing, Professor Bartholow prescribed, in the clinic:

℞ Ext. grindeliæ fluidi.....
Ext. quebracho fluidi....*aa* ♏ xx
Ammonii iodidi.....gr. v. M.

As a tonic in the asthenic type of fevers Prof. Gross advises the following:

℞ Quiniæ sulphat.....gr. ij
Tinct. ferri chloridi.....
Acid. hydrochlor. dilut..*aa* gtt. xv
Tinct. nucis vomicæ.....gtt. x
Syr. zingiberis.....f ʒij. M.

Sig.—This amount ter die,

Instead of nux vomica $\frac{1}{10}$ grain of strychniæ sulphas may be employed.—*Col. & Clin. Record.*

In lymphadenoma, following scarlet fever, in a girl of seventeen years, Prof. Da Costa prescribed

℞ Acidi arseniosi..... .....gr. $\frac{1}{10}$
Ferri sulph.....gr. ij M.

Sig.—The pill ter die.

Over the enlarged glands rub:

℞ Ung. iodi.....
Ung. belladonnæ.....*aa* ʒ ss.
Camphoræ.....gr. v. M.

In atonic dyspepsia, Professor Da Costa prescribed.

℞ Tinct. nucis vomicæ.....gtt. x
Tinct. capsici.....gt. j
Tinct. cinchonæ comp.....f ʒ j M.

Sig.—Ter die.

To this was added pepsin, gr. iij-v, with each meal.

DR. OSLER'S GULSTONIAN LECTURES. — This year's lenten lectures at the Royal College of Physicians, London, were opened on Thursday, February 26th, by Dr. Osler, of Philadelphia, who choose for the subject of his Gulstonian Lectures the fascinating disease known as ulcerative endocarditis. His first lecture was devoted to the naked eye and microscopic pathology of the affection, its clinical history and etiology being left for discussion in the lectures to be delivered on Tuesday and Thursday in the following week. The lecture was mainly *ex tempore*, lasted the ideal forty-five minutes, and was unusually well attended. Dr. Osler, as might have been expected, was most cordially greeted, and there can be no doubt that his lecture was such as was well worth while his coming across the water to deliver.—*London Medical Times*, February 28, 1885.

KAIRIN.—Kairin, although comparatively little used as an antipyretic, has grown in favor particularly in France and to some extent in Germany. Its use has been more general in febrile diseases. Having been satisfactorily employed in pneumonia, scarlatina, measles, erysipelas, septicæmia, peritonitis, etc., it is considered a safe and valuable antipyretic, worthy of further trial. The usual dose of sulphate of kairin is about eight or ten grains every two hours till the temperature is reduced.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science Criticism and News.

☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

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The LANCET *has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

LACERATION OF THE PERINEUM.

A good deal, no doubt, of what even the most gifted medical journalist feels called upon to say is very stale and incipient to some of his readers. In this connection it is always well to remember that all are not specialists, nor have all reached the acme of universal medical knowledge. Moreover the bulk of the profession is scattered over the face of the country, far away from the centres of learning and concrete mental activity. What may be stale, and even incipient, to the college professor or hospital physician may be interesting and profitable reading to the general practitioner. Besides, the journalist does not pretend to write for the benefit of the specialist, or the few, but for his readers as a whole. This is our apology for referring to so common-place a subject as laceration of the female perineum.

The race of obstetricians just passing away gave themselves but little trouble or anxiety about the perineum. A partial rupture was regarded as of small consequence, while a more extensive one—if not complete, however deplored, yet was a thing to be patiently endured. Indeed, there is good ground for the belief that ruptures, both great and small, were not uncommon, all unknown to the learned attendant. Nor is it certain that even extensive lacerations do not occur without the knowledge of the supposed accomplished obstetrician of the present day. The former had some excuse for his lack of watchfulness, but the latter, who is constantly admonished from every side, is scarcely able to furnish a valid excuse for his carelessness. Without doubt, lacerations of the perineum are becoming more frequent. It is not enough to say that, in the present day, cases which formerly were undetected, or, if detected, were not reported, are now more frequently discovered and made known, both to the patient and the profession. That is quite true, but, in addition, we know full well that artificial causes operate more extensively than formerly in producing this accident. The forceps is a great boon to woman and no one would abolish it, yet it is to its more common use that we must attribute the increased frequency, and often the more aggravated nature of perineal laceration. Of course, the perineum may be, and often is, torn by the natural efforts alone. Most of us have often been consulted by some old woman suffering, all unconsciously, from an ancient rupture of the perineum. She complains of falling of the womb, difficulty in making water, some kind of trouble about the lower bowel, besides a score of other troubles, but is utterly oblivious as to the real cause of all her suffering. Yet such a one might never have been delivered with forceps, and sustained the injury without any instrumental or undue interference.

No one will deny that the use of the forceps tends to greater liability to rupture. This arises from three causes at least. The first is the tendency under the excitement, and demoralization of the moment perhaps, to deliver too rapidly; secondly, delivery of the head while still grasped by the forceps; and thirdly, slipping of the instrument. Someone may be ready to exclaim that all these causes are avoidable. We think the experience of the most skilful contradicts such a position, and that the perineum will sometimes be ruptured while the forceps are held by the most "cunning" of hands. Rapid distension may be called for, or the tissues may have but little cohesion; uterine effort may be feeble or extinct, and the head may have to be delivered contrary to general rule, still grasped by the forceps; and a contracted pelvis, or a large, unyielding head, may render accurate manipulation impossible, and so cause a slipping of the instrument, an accident, of course, not always, though sometimes, followed by laceration. Few practitioners of extended experience, we feel convinced, but have had occasion to lament more

than once the presence of laceration, more or less serious, after a forceps delivery. Even Professor Goodell is not above confessing that such a casualty has occurred in his hands on several occasions. These remarks are not made in the interest of bunglers, but rather to make good the statement that the more frequent use of the forceps tends inevitably and unavoidably to an increase in the occurrence of the accident under consideration. After making due allowance for unavoidable cases, there is much room for the belief that a good deal of suffering is inflicted by the unskilful use of the forceps. It is manifestly the bounden duty of every obstetrician to study to maintain a cool head, a steady hand, and an avoidance of all the causes known to lead to this untoward accident.

When laceration occurs, as occur it will now and again, no one in his senses will leave the woman to her fate, that is, if the laceration be at all serious. The train of evil consequences following a considerable perineal rupture outstrips by far the consequences of an equal breach of continuity of tissue, not associated with the vital organs, in any other part of the body. Prolapse of the uterus, vesical and rectal protrusion, unhealthy vaginal and uterine discharges, erosions of the cervix and other uterine complications, difficult micturition, constipation, besides a host of general troubles, as neuralgia and indigestion, having their seat in reflex action, are a train of evils of so aggravated a nature as to call for the prompt execution of the measures best calculated to ward them off. The safest, best and only treatment, is the restoration of the part. Immediate closure of the breach is now insisted upon by the profession everywhere. For this several cogent reasons may be advanced. Delay in closing the wound exposes the patient to blood-poisoning; experience shows that the primary operation carefully performed is almost always successful; the primary operation is comparatively easy, and can be readily performed, when necessary, without the aid of a skilled assistant. In the secondary operation the necessary dissection is the most painful and delicate part of the work; in the primary operation nothing of this kind is called for; the parts are simply brought into their natural place and held there by approved supports. Lately new methods have been proposed but the quilled suture still holds its place for all extensive rents. In slight rents a single simple suture is all that is required. Dr. Alloway, of Montreal, first recommended the single suture operation in all cases we believe, not involving the sphincter or bowel. Perfect coaptation is the great secret of success in union by first intention, in all wounds, and nowhere is this more true than in wounds of the perineum. The after treatment of these cases is of great consequence. The wound must be carefully guarded against the action of the urine and lochia, and some approved antiseptic should be used, not only as an application to the wound but also as an injection. The conclusion of the whole matter is, that the obstetrician of the present day must be on the alert for perineal rupture, and be prepared to repair it on the instant when it occurs.

SANITARY INSPECTION.

The history, character and progress of former epidemics of cholera in Europe point to the probability of an invasion of the disease in this country during the coming summer. It is therefore high time for the authorities to be aroused to the necessity of adopting such means as will prevent its incursion or mitigate its severity should it unfortunately reach our shores. The State Board of health for Illinois, in view of the expected invasion, has ordered a sanitary survey of the State and a house to house inspection, so that all sanitary defects and evils may be corrected as expeditiously and with as little expense as possible. The inspectors are authorized to request the prompt correction of all defects, and the removal of all nuisances as soon as they are discovered, and all persons neglecting or refusing to comply with the request shall be prosecuted according to law. The inspection will be conducted under the supervision of the health authorities wherever such exist, and where there is no such organization a health officer shall be appointed.

This action of the Illinois board is worthy of imitation, and we trust that immediate action will be taken by the authorities in our own city and elsewhere in the Dominion. It is important that this work be begun as soon as the weather will permit; *and it is especially desirable that certain details be attended to at the earliest practicable moment.* For example the emptying, disinfecting, filling with clean earth, or other necessary treatment of privy vaults, should be completed before warm weather

comes to interfere with such work, or before the appearance of a case of cholera makes it dangerous to attempt it. To this end, wherever the conditions make such action necessary, a proclamation or health notice should he issued, directing the immediate prosecution of such work.

THE ONTARIO ANATOMY ACT.

The bill before the Legislature of Ontario bids fair to become law, and we trust that no unforseen circumstance will arise to prevent its passing in the shape in which it was amended by the special committee to which it was referred. The bill is in Dr. Baxter's hands, and we have every reason to believe that no serious opposition will be raised against its provisions when it reaches the third reading. There is very great need of such a measure; the supply of material obtained under the old act was wholly inadequate to the demand. The number of medical students has greatly increased while the amount of anatomical material remained about the same; during the past session the supply was wholly insufficient, and the teaching of practical anatomy was greatly retarded in consequence. The Act provides that the bodies of those found dead, or dying in public institutions, (Lunatic Asylums excepted), and not claimed by relatives, or friends who are willing to bear the funeral expenses, shall be handed over to the medical schools for anatomical purposes. This is the essential clause, and if passed, will, it is confidently believed, give an abundant supply of material. The remaining clauses provide for the appointment of inspectors and in a general way secure the machinery for the proper working of the Act.

"UNPROFESSIONAL" ADVERTISING.—An epidemic of diphtheria in Halifax, N.S., is made the occasion for a fresh outbreak of "unprofessional" advertising among our confreres down by the sea. A disgusted M.D. writes to the Halifax *Mail* in regard to the matter in the following terms:—"I was surprised to see by your issue of last night that this serious question has begun to be made a pretext for puff and quack advertisements by some few of our medical brethren in this city. This action on their part is reprehensible in the extreme, and most derogatory to our profession, and would not be tolerated in England, or elsewhere in this country; it is also most prejudicial to the matter under consideration and the public good. All praise is due to Dr. Campbell for the stand he has taken in ventilating this important subject, but the same cannot be said respecting others, who are too palpably endeavoring to foist their names before the public in this irregular manner; and it is to be hoped that the press of Halifax will not prostitute their columns by allowing them to be channels for this discreditable system of spurious medical advertisement. It was only very lately that the leading medical journal of Canada had occasion to censure severely one or two medical men in this province for a similar offence, and it is to be sincerely hoped that this stain on our profession in these parts is not about to be increased by a repetition of these improper and unprofessional practices."

PNEUMONIC FEVER.—In an article on relapsing or intermittent pneumonia in the "British Medical Journal" of recent date by Sir Andrew Clark it is said: "Every one appears to have asked if pneumonia is not a fever, but scarcely any one has asked if pneumonia is really an inflammation." In this connection Andrew Clark refers to a lecture delivered by himself at the College of Physicians in 1866. These views were long since advanced by Professor Austin Flint, of New York, and are still held by him in his valuable work on the practice of medicine. He says that pneumonia is the local manifestation of a fever, and should be called "pneumonic fever." He gives the following reasons, with others, for the belief that it is a fever: The large quantity of exudation which is derived from the pulmonary artery—hence from carbonized and not from oxygenated blood—this exudation being ultimately completely absorbed, the air-cells returning to their normal condition. Moreover, pneumonia is never caused by the extension of any local process, such as abscess, gangrene, or any kind of local injury. Again, the disease is ushered in by a distinct rigor, and the temperature rises rapidly before there are any local manifestations. The spleen often becomes enlarged, and the patient becomes jaundiced.

MEDICAL JOURNAL ADDRESSES.—We have just received from the Illustrated Medical Journal Co., of Detroit, Michigan, several sets of their perfo-

rated, adhesive medical journal labels. The list includes besides the journals of the United States that are devoted to medicine, pharmacy and hygiene, those of the Provinces of Canada as well. Four complete sets will be mailed postpaid for fifty cents, on addressing the publishers above named. They are just what every physician needs for addressing his reprints for journal notice, and medical colleges for addressing their announcements for a similar purpose.

HYPOSULPHITE OF SODA AS A DISINFECTANT.—The difficulty of finding a satisfactory disinfectant with which to destroy fœtor in cases of cancerous ulcers, is well known. We have used a saturated solution of hyposulphite of soda added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was then covered with rags steeped in the solution. The granulations were kept clean, and the fœtor was well kept under. It is cleanly, has no smell, does not stain, and is not expensive.

CLIMATE OF COLORADO.—Dr. R. B. Teller of Aspen, Colorado, writes that the climate and mineral waters of Glenwood and vicinity are exceedingly well adapted to the cure of rheumatism and phthisis. Phthisical patients have been benefited to an extent that would seem perfectly incredible to those not familiar with the climate. Persons suffering from either of the above diseases, or with asthmatic affections, he says, may rely upon obtaining certain relief in Colorado.

HALIFAX MEDICAL SOCIETY.—A meeting of the medical profession of Halifax, N.S., was held on the 14th ult., to organize a medical society. After some discussion the following officers were elected for the ensuing year:—President, Hon. Dr. Parker; Vice do. Dr. Rigby; Secretary-Treas. Dr. Lathern; Committee on by-laws, Drs. Cowie, Rigby and Campbell; Executive Committee, Drs. Tobin, Cowie, Farrell, Almon, Wickwire.

THE TREATMENT OF RINGWORM.—Mr. Alden Smith, in the "British Medical Journal," speaks very highly of a solution of chrysophanic acid in chloroform for the cure of ringworm. The chloroform will dissolve the fatty matter in the hair follicles, thus facilitating the acid in getting to the parasite, which it destroys. The prescription is used in the strength of seven grains of the acid to the ounce of chloroform. The hair, if there be any to speak of, should be closely clipped.

NIGHT COUGH IN CHILDREN.—The occurence of a troublesome night cough in children is met with frequently. Dr. McCoy. of Philadelphia, in an article in the *Med. News* draws attention to this affection and claims that it is due in most cases to nasal catarrh with its accompaning secretion, etc. During the day the discharge passes away, but during the night it accumulates and causes irritation, or passes down the posterior nares and into the pharynx. The treatment recommended is to cleanse the nose before the child is put to bed by means of a spray composed of an aqueous solution of an alkali.

LOCAL ANÆSTHESIA.—It is said upon good authority that local anæsthesia may be readily produced by applying with a camel's hair brush the following mixture:

℞ Chloral,
Camphor, . . . *aa* ʒ j,
Morph. sulphat. . . ʒ ss,
Chloroform, . . ʒ j. M.

Sig. To be applied with a brush to the area to be incised.

ONTARIO MEDICAL COUNCIL ELECTIONS.—We publish in another column the address of Dr. Allison to the electors of King's and Queen's territorial Division. So far there does not appear to be any opposition to the worthy doctor's candidature, and we hope to see him elected by acclamation.

Dr. A. S. Fraser, of Sarnia, has been appointed Returning Officer for the Western and St. Clair Territorial Division, *vice* Dr. Richardson, of Chatham deceased.

A CONJOINT SUMMER SESSION.—A summer course of lectures, clinical and practical, will be given by the acting staff of the Toronto General Hospital connected with the two medical schools. The session will commence on the 1st of May, and continue ten weeks. The lectures will be delivered in the theatre of the hospital. See announcement in another column.

CASE OF TRIPLETS.—Dr. Phelan, of Kingston, reports a case of confinement in which a woman

gave birth to three healthy living children, two girls and a boy—all living. She was 12 hours in labor before the first birth; 25 minutes later, the second child was born; and 35 minutes later, the third was born. Each child had a distinct placenta.

APPOINTMENTS.—Dr. A. C. Panton, (Trinity) has been appointed to the chair of materia medica, and Dr. K. A. J. McKenzie, (McGill), to the chair of clinical surgery in the Medical College of Portland, Oregon. Dr. A. Robillard has been appointed a commissioner under the Liquor License Act.

Hon. Dr. Parker, of Halifax, Dr. Page, of Truro, and Dr. McGillvary, of Sydney, have been appointed members of the Nova Scotia Medical Board.

CORONER.—Dr. C. Sinclair, of Aylmer, has been appointed coroner for the Co. of Elgin, and Dr. A. C. Bowerman for the Co. of Prince Edward, Ont.

INDEX MEDICUS.—We are pleased to notice that this valuable monthly publication is to be revived. It will be published by Mr. Geo S. Davis of Detroit. The editors are Drs. Billings and Fletcher of Washington.

THE death of Prof. Frerichs, of Berlin, in announced in our Foreign exchanges. He was a man of great ability and his death is a serious loss to German medicine. The death of Dr. Ellerslie Wallace, of Philadelphia, is also noticed in our exchanges.

Notes, Queries and Replies.

BRITISH QUALIFICATIONS.

To the Editor of the "CANADA LANCET."

SIR,—In reply to Queror in last number of the "LANCET;" I wish to say that I spent one month in the London hospitals, obtaining great insight into special and general diseases. There are some forty hospitals in the Metropolis, but the material is not presented to the best advantage *i. e.* for a graduate to learn much in a short time—more especially in the special sub-divisions of the science.

I attended the Edinburgh New Royal Infirmary for four months devoting four hours per diem to practical work, one hour to grinds and the remainder of the day to study, etc. I succeeded in passing the first conjoint examination of the R. C. P. & S., Ed., and the Faculty of P. & S. of Glasgow. I may say the feeling of equality extended to a Canadian confrere, materially assisted my chances of gaining practical knowledge. I believe Glasgow also to be a good place to obtain practical instruction, as students are requested to familiarize themselves with the ward work.

I next took Cook's tickets from Scotland to Hamburg, Berlin, Vienna, Paris, London and intermediate points, costing $75.00, with $2.00 per day for hotel coupons, and extras additional while on the road. The expenses, when a permanent stay is made in any one place, can be made to suit circumstances. Much was seen that I never expected to see here, and my experience and confidence was advanced many years. Expenses on the ocean can be arranged to suit individual taste. I purchased a first-class return via Allan Line by Quebec and Halifax with R. R. reduced rates for an unlimited season. Expenses in Great Britain I should judge to be about $5.00 to $7.00 per week for a long period, with $130.00 for examinations, $25.00 for registration, and a few pounds for hospital fees. Extras according to special requirements. For the regulations of the respective corporations write to Dr. James 11 Albyn Place, Dr. J. Wyllie, R. Infirmary, Mr. Bell, F.R.C.S., Edinburgh, the secretaries of the triple, physician and surgeon qualifications.

The conjoint examination is written, clinical, and oral and lasts a week or more. The subjects are: Medicine (including Therapeutics, Medical Anatomy and Pathology), Clinical Medicine and Surgery, Surgery (including Surgical Anatomy, Operative Surgery and Surgical Pathology), Midwifery (including Gynæcology), Medical Jurisprudence and Hygiene. The ward examinations include both medical and surgical cases, besides testing urine and recognizing urinary crystals, etc., bandaging and the use of surgical instruments.

A Canadian must produce his diplomas and other certificates which they demand. The advantages received from the practical work should be the primary and the examinations the secondary object to take one's time and attention. In case of failure at the examination one has the privilege of trying again in three or six months after paying $25.00 entrance fee which many are obliged to do.

W. F. FREEMAN.

WALKERTON, Ont.

USE OF PICROTOXINE.

To the Editor of the "Canada Lancet."

SIR,—Would some of your readers give their experience in the use of Picrotoxine in the sweating of phthisis, and also in what liquid it is best dissolved.

THERAPEUTIC.

New Brunswick, Mar., 85.

Books and Pamphlets.

THE LAW AND MEDICAL MEN, by R. V. Rogers, Jr. of Osgoode Hall Toronto, Barrister-at-Law. Toronto: Carswell and Co.,

This little work consisting of about 200 pages, fills a gap in the library of both the physician and lawyer. It deals with the laws relating to the practice of medicine, fees, (who should pay the same), civil and criminal malpractice, privileged communications, expert testimony, defamation, relations with patients, dissection, resurrection, etc., etc. In discussing the subject of malpractice he cites the following, page 61, (J. Woodward in *McCandless v. McWha* 22 Pa Rep. 261) "A patient is entitled to the benefit of the increased knowledge of the day. The physician or surgeon who assumes the healing art is bound to be up to the improvements of the day. The standard of ordinary skill is on the advance, and he who would not be found wanting must apply himself with all diligence to the most accredited sources of knowledge." Where would the fossilized members of the profession who never read a medical journal or any new work on medicine be found in the face of the above ruling?

The book is a very interesting and readable one and should find a place in every physician's library, in view of the fund of information it contains, The statements of law contained in the book are in nearly every instance the rulings of the judges in the particular cases, with citations. We would suggest to the author the propriety of printing the code of medical ethics, as an appendix, in the next edition.

THERAPEUTICS OF THE RESPIRATORY PASSAGES.—By Prosser James M.D. London.

This is one of the best of the monthly issues of "Wood's Library of Standard Medical Works." Every valuable medicament employed in the treatment of the affection of the respiratory passages is subjected to impartial consideration. The chapters on alcohol, denutrients, and antipyretics are peculiarly instructive, clearly indicating that the author whilst free from the sentimental prejudices of the extremists, is yet gifted with that spirit of candour which should ever be the dominating influence in medical science. The book cannot be read by any practitioner without great profit.

DISEASES OF THE URINARY AND THE MALE SEXUAL ORGANS.—By W. T. Belfield, Chicago. W. Wood and Co: New York.

Dr. Belfield has had the advantage of practically studying the above diseases in a prolific region, and his book presents abundant proofs of his careful observation. In a large city like Chicago, teeming with a very fast population, with strong propensities to illicit pleasures, and exempt from abhorrence of facile divorce, the diseases treated of by Dr. B must constitute no trivial part of daily routine, and and if they are sedulously cultivated, the pecuniary results must be very enticing.

DOCTRINES OF THE CIRCULATION, by J. C. Dalton, M.D., Emeritus Prof. of Physiology, College of Physicians and Surgeons, New York. Philadelphia: Lea Brothers & Co. Toronto: Williamson & Co.

This is a most interesting and well written handbook of the doctrines of the Circulation from Aristotle, Praxagoras, School of Alexandria, Galen, Period of Renaissance, to the dawn of light on this subject, following the discoveries of the Professors of the Universities of Padua, Pisa, Bologna, and Rome. The author also gives the subsequent opinions of Servetus, of the transfer of the blood from the right side of the heart to the left, taking place in the lungs, and not through the septum of the ventricles; also the discovery of the valves in the veins by Fabricius ab Aquapendente, their form, and speculations on their use. He next refers to the doubts of Harvey regarding the correctness of these theories, and his subsequent discovery of the peripheral circulation from the arteries to the veins, and of the return circulation of the blood through the veins to the heart. Space will not permit further notice of the scope of this work, which is of great research, and one that we welcome as a valuable addition to medical literature.

Births, Marriages and Deaths.

On the 2nd ult, J. B. Howell, M D., of Thornbury, aged 34 years.

On February 9th 1885, wife of Dr. A. McTavish, Staffa, Ont., aged 39 years.

THE CANADA LANCET

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Original Communications.

OVARIOTOMY.

BY DR. A. M'DONALD, EDINBURGH.

Read before the Obstetrical Society of Edinburgh.

CASE I.—M. P., aged 23, unmarried, was admitted in January 24, 1884, complaining of a large swelling in the abdomen, of pain in the right side, of sickness, and of only being able to digest milk diet. Two years ago she suffered severe pain in right side and inability to eat. In August last she first noticed the swelling, and since that time it has rapidly increased in size. She had considerable menorrhagia and mettorrhagia from May till August last year.

Condition on admission.—Abdomen extended to size of eight or nine month's pregnancy by a tumor of slightly uneven outline, but, on the whole, of smooth contour. Tumor projects very far forward inferiorly, and seems to be more to the right than left side. Percussion note is dull over anterior surface of tumor, clear in flanks from back. Tumor appears to move slightly under anterior wall with forced inspiration. Measurement round umbilicus 35¼ inches; about 1½ inches below umbilicus measurement is 38 inches. From right anterior superior spine to umbilicus, 9¼ inches. From left anterior superior spine to umbilicus 8¾ inches. From symphisis pubis to umbilicus, 8¼ inches. *Per vaginam.* Tumor presses down into anterior half of pelvis, displacing uterus to the left and backwards. Uterus appears movable at brim. No part of tumor is found in the pouch of Douglas. Sound enters towards the left and upwards, nearly 3 inches. *Per rectum.* Small body of uterus is distinctly felt apparently separate from the body of the tumor. On February 6th the patient was, after due preparation, submitted to operation. The room had been sprayed for some hours, and the usual antiseptic precautions were employed, except the use of the spray during the operation. The abdomen was opened with ease. It was then found that the tumor was attached to the right broad ligament, and that there were considerable adhesions of its upper anterior part with the great omentum. Otherwise the tumor was free; the only considerable cyst in the tumor was tapped and about a pint of fluid run off. The edges of the tumor were now surrounded with sponges, and the tumor incised. The hand was then passed into the interior, the multitude of small cysts forming its mass were then broken up, and the contents squeezed out. In this way the tumor was lessened in bulk so as to pass through the abdominal wound, which originally measured about 3½ inches. The omental adhesions were now fully exposed, and the attached part of the omentum was divided into a number of separate portions and tied by catgut ligatures. The pedicle was very broad and rather thin and short. It was transfixed and tied with silk ligature by the Staffordshire knot. As it seemed to ooze a little after being tied and the tumor separated from it, the loose ends of the thread were brought round the base of the pedicle and again tied. The sponges were now removed from the abdomen and the whole cavity thoroughly sponged out. The omentum was carefully inspected and no bleeding point discovered. The ligature was now cut short and the pedicle dropped. The abdominal wound was secured by deep and superficial sutures and the wound dressed with protective and salicylic wool and a flannel bandage. The patient was put to bed, surrounded by hot bottles, and a brandy enema administered. The operation lasted 1¼ hours. The solid weight of the tumor was 4 lbs. and the fluid above 12 lbs. The patient's recovery was excellent, though somewhat attended by persistent sickness and vomiting, which lasted for the first ten days after the operation, during which time she was fed by enemata. In the first few days the temperature ranged from 100 F. to 101·8, after that it became normal and remained so. Deep stitches removed on the seventh day, union complete. Patient improved daily after vomiting ceased, and was dismissed on March 10th, 1884, perfectly well.

Remarks.—Since the patient returned home I have heard that she continues to keep well. It is to be noted that the way the tumor was fixed

above by the omentum, and below by the pedicle, rendered its removal a little difficult. The fact, also, that its mass being made up of small cysts with thick contents did not permit of its bulk being materially lessened by tapping, I was obliged to incise it and break up its contents. Some anxiety was caused by finding that the fluid contents of some of the cysts, when subjected to microscopic examination by Dr. Foulis, were found to contain sarcomatous elements. This led to a special examination of the tumor,and the detection of sarcomatous thickening of certain portions of its walls. But, as there were no proliferating masses on any part of the surface of the tumor, we have the best reason to expect that the patient will do well, having escaped infection from the sarcoma.

CASE II.—M. P., æt. 21, no children, admitted December 18, 1883, complaining of pain in the right groin. Twelve months ago patient was suddenly seized one evening with a sharp pain in her right side ; mustard was applied and relief was obtained for the time. From that time till now patient experienced at times a feeling of heat in the side. Menstruation natural. Health always good.

Condition on admission.—General appearance flabby and chlorotic. Abdomen distended to about the size of a seventh month pregnancy. The tumor is more developed towards the left than the right. Measurement round the most prominent part of tumor, about an inch below umbilicus, is 30¼ inches. From umbilicus to right anterior superior spine, 6¼ inches ; to left anterior superior spine, 6½ inches. Tumor feels smooth all over, appears to move with respiration. Percussion in right flanks clear, on left somewhat dull. Anteriorly over whole tumor is marked dulness. Fluctuation and fluid thrill are felt throughout the tumor. *Per vaginam.* Posterior part of pelvis and entire inlet are blocked by a tumor which moves in unison with abdominal tumor to a certain extent. The uterus is displaced to the left and upwards. Cervix uteri can be reached, but with some difficulty. Sound passes up and forwards without pain 2¼ inches.

Dr. Macdonald performed ovariotomy on Dec. 26, 1883. On entering the peritoneal cavity the omentum and a portion of the bowel were found adherent to a large cyst, which occupied the right side of the abdomen. On the left side the same cyst was bare, the aspirator was passed, and about 90 oz. of a dark amber colored fluid drawn off. On attempting to remove the cyst it was found to pass deep down into the very base of the pelvis, so that it was impossible to complete the removal without 1. separating the bowel adhesion : 2. opening the broad ligament so as to get the cyst gradually enucleated from between its folds. In doing so some hemorrhage occurred, necessitating very numerous ligatures. The tumor, towards the uterine end, was firmly adherent to the broad ligament, so that the latter had to be partly included in the pedicle and partly torn into small pieces and tied. The pedicle proper was very thick and hard and short, and proceeded from the right upper angle of the uterus. On examining for the left ovary there was found protruding from the left broad ligament, in the site of the normal ovary, an elongate bowel-like cyst, with exceedingly thin walls, which occupied the left iliac and left lumbar regions. Over its anterior surface, and firmly adherent thereto, passed a considerable knuckle of intestine. As far as could be judged, the cyst bulged between the layers of the meso-colon. The bowel was firmly adherent to this cyst down to its pedicle proper, which proceeded from the left upper corner of the uterus in the same manner as the other cyst from the right. There was considerable difficulty and much bleeding during the separation of the bowel from this cyst, numerous ligatures being used. During process of separation of cyst it burst, and a large quantity of clear serous-looking fluid was squeezed out. Pedicle was now secured close to uterus, and its other adhesions tied in portions and divided. There was seen to be still some oozing from right side and floor of the pelvis, but no distinct bleeding points could be descried. Abdominal wound was brought together in the usual fashion after the cavity had been well sponged out, wound dressed, a glass drainage-tube having been introduced into its lower angle. Patient put to bed with hot bottles, and a brandy enema given. The patient was much exhausted after the operation, and a second enema was given. On day of operation at 5 p.m. pulse was feeble, 130 per min. Dressing changed. There was squeezed from sponge and sucked from glass tube 5 oz. of sero-sanguineous fluid. An ounce of brandy ordered every 2 hours. 10 p.m.,

pulse stronger; temperature, 100.2. [Dec. 27th 10 a.m.: Wound looks healthy; 9 drachms sero-sanguineous fluid sucked from tube. Pulse firmer, ordered to diminish brandy by one-half. 5 p.m., Dressing changed; 8 drachms sucked from the tube. Temp. 100, pulse 139. One-ninth grain of morphia and $\frac{1}{60}$ gr. atropine given hypodermically. Dec. 28, 10 a.m.: Patient seems easier. 1 oz. sanguineous fluid got from tube and sponge. Temp. 99.2, pulse 128. 2 p.m.: Temp. 100.4, pulse 140. Dec. 29: Hypodermic of morphia and atropine given at 1.30 a.m. and 10.30 a.m. At latter hour discharge was septic and offensive. Dr. Macdonald washed out abdominal cavity with warm carbolic lotion 1-100. 3 p.m.: Temp. 100.8, pulse 150; another hypodermic given. 10 p.m.: Abdomen again washed out. 12 p.m.: Temp. 102.4. Dec. 30: Temp. gradually rose to 103, then 104 at 6.50, when patient died. No post mortem allowed.

Observations.—This case presents points of special and unexpected difficulty. Considering that there was no free fluctuation in the tumor and that the patient was a healthy woman, there appeared no ground to expect unusual operative difficulty, except in the fact mentioned in the case that the tumor projected deeply down on the right side of the uterus. It would almost appear that in this case we had to deal with two huge enlargements of the Fallopian tubes. At any rate, from the peculiar shape of the tumor on the left side, there is the best reason to regard this as most probably of tubal origin. The parts comprising the broad ligament were so disfigured by pressure of the cysts that it was impossible even with the most careful scrutiny, to detect any trace of ovaries or tubes to make certain that the cyst originated in the tubes. But the close connection of each pedicle the tumors possessed with the upper angle of the uterus seems to imply an origin from the tubes. I cannot help thinking that, notwithstanding the severity of the case, all might have gone well had she not had in the large wound some rather putrid pus. The drainage-tube seems to have been a source through which the putrid fluids were made septic. I need hardly say that we used every precaution in our power by protecting the end of the tube from the air to avoid this result. Be this as it may, it is evident that the patient died of septicæmia in spite of all efforts.

POLYPOID FIBROMA OF THE BLADDER.

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.

Prof. of Surgery Trinity Medical College, Toronto; Surgeon to Toronto General Hospital, etc.

Primary neoplasms of the bladder are exceedingly rare, and when they occur attract no small degree of interest from a surgical point of view. Sir Henry Thompson in his work on the Urinary Organs (second edition) says: "Tumors proper to the bladder are of rare occurrence. Simple fibrous growths, chiefly in the form of polypi springing from the walls of the bladder and wholly unassociated with the prostate, are the rarest of all forms, known to me personally only in museums. Prof. Gross, of Philadelphia, in his admirable work on "The Urinary Organs" also states that polypoid fibroma is exceedingly uncommon, "excluding the cases recorded by Lusitanus, Kirchner, Sylvius, Rollin and other older authors, and those in which villous hypertrophy is a prominent feature of the growth, fifteen cases of fibrous polyp have been collected, of which eight occurred in males and seven in females, their ages varying from thirteen months to 56 years. In only six were the subjects impubic, the average age being the 20th year. The duration of the disease ranged from five weeks to three years, the average being fourteen weeks. Dr. Stein, of New York, in an excellent monograph on this subject states on the other hand, that polypi are more common in early life than any other kind of tumor. The subject of the present history was a male child aged one year and eight months, the youngest of a family of eleven; eight living and three dead. One died of inflammation of the bowels, another of croup, both under one year, and the third a little girl of five years of age was accidentally killed. The parents were perfectly healthy, and this child was healthy at birth, but at the age of three months he had some eruption of the scalp which the doctor called "scald head." This was soon relieved by treatment, after which he seemed perfectly healthy until some months afterwards when he appeared to be suffering from internal pain and swelling of the scrotum. The parents consulted the ordinary medical attendant, who thought the child was ruptured, and recommended them to obtain the advice of a neighbouring practitioner. Upon examination he diagnosed hydrocele and removed the fluid. This was about two weeks after the child first began to complain.

At this date there was no suspicion of anything being wrong with the bladder. The little patient seemed better for a short time after the removal of the fluid, but soon began to complain as before, especially when he attempted to urinate. The effort at micturition was attended with a good deal of straining and bearing down pain, and the child was constantly pulling at the prepuce. The parents again took the patient to the consulting surgeon and gave him an account of the symptoms. He immediately suspected stone of the bladder. He did not sound him at the time, however, as he had no suitable instrument, but told them to call back in a week or ten days. It was about two weeks before they returned, the symptoms evidently not being very urgent at that time. The surgeon administered chloroform, introduced the sound and examined carefully. He could detect no stone, but felt some thickening of the anterior wall of the bladder. Considerable hemorrhage followed the introduction of the sound. The child continued to strain very much in urinating, and now and again seemed threatened with retention of urine. A few days after the introduction of the sound, there was again some hemorrhage from the bladder; these were the only occurrences of hemorrhage. The amount of blood was not great—probably about half a teacupfull. The surgeon in charge then advised the parents to take the child to the Toronto General Hospital for treatment, and he was admitted under my care. At the time of his admission his mother stated that he had not passed any urine for nearly 24 hours. The abdomen was enlarged and felt quite hard as if the bladder was ready to burst. I introduced a catheter, but was astonished to find that only a small quantity of urine mixed with muco-pus escaped. On placing my hand over the abdomen it still felt quite hard, and there appeared to be a solid mass between the point of the catheter in the bladder and my hand, for which I could not account. On examination per rectum, I made certain that the instrument was in the bladder, and the posterior wall of that viscus felt quite normal. On the supposition that it might be an abscess in the abdominal wall, I ordered the child to be put to bed, to have a warm poultice applied, and a few drops of laudanum administered. This gave great relief. As might have been expected there was considerable febrile disturbance; skin hot and dry. The bowels were kept freely open. On the following day the catheter had again to be introduced as the child was still unable to pass any urine. After drawing off the urine, which was small in quantity and mixed with pus, I introduced a very soft catheter with the view of leaving it in, but it was not long until the child, in one of its fits of straining which came on at intervals of a few minutes, forced it out with great violence. I then introduced a small silver catheter with a short beak and tied it in. Through this the urine escaped for the next two or three days. In the meantime there was no amelioration of the symptoms—the child was evidently growing rapidly worse. I had held out no hopes of the child's recovery to the mother from the first. Fearing that the catheter might increase the irritation I removed it, and drew off the urine as required by means of a gum-elastic catheter. Although somewhat puzzled at first in regard to the diagnosis, I had now come to the conclusion from a close scrutiny of the history, that it was a case of polypoid fibroma of the bladder. I stated my conclusions to several of my confrères, but they seemed incredulous. Some thought it was a perineal abscess, and advised me to make an incision. This opinion was, in some measure, justified by the fact that the urethra was enlarged, and pus from the bladder escaped through it during the last day or two of the child's illness, but as I had watched the case closely and examined the parts carefully, I felt certain there was no abscess. The passage of a small polypus about this time verified my diagnosis. The child died on the 11th day from the date of admission, and a *post mortem* examination revealed the true nature of the case. The bladder was completely filled to distension with polypoid growths which sprang from a pedicle about an inch in width and a quarter of an inch in thickness, and was attached to the left anterior wall of the bladder. The coats of the bladder were thickened except at the summit, which had ultimately given way by ulceration. Urine and pus escaped into the abdominal cavity and brought on fatal collapse. The ureters and pelves of the kidneys were very much dilated, and the kidneys more or less congested. The urethra and neck of the bladder were also dilated. The polypoid growths which were globular in shape, smooth and even, have shrunken very much since placing the specimen in alcohol. Under the microscope the tissue appears lax and

succulent, and made up of delicate interlacing filamentous tissue. It is not very vascular, and is covered with a reflection of the mucous membrane, the cells of which are normal. Prof. Gross tells us in his admirable work above referred to that "these tumors occasionally co-exist with urinary calculus, or they may be encrusted with crystals of triple phosphates, and that they evince a remarkable predeliction for the neck of the bladder."

The symptoms of polypoid fibroma are chiefly of a mechanical character, viz. : difficulty in micturition, sudden stoppage of the flow, painful retention accompanied with great straining, requiring the frequent use of the catheter. The occasional passage of a small polypus as in the present instance, will at once establish the diagnosis. There is usually very slight hemorrhage, which may only be occasioned by the introduction of instruments. There is frequently pain at the head of the penis as in stone of the bladder. In females a protrusion of the tumor from the urethra is a valuable symptom. In this connection a most interesting case was published by Mr. Stanley in the *Medical Times and Gazette* of 1852 (page 106) in which, from continued retention of urine, some of it was forced into the imperfectly closed urachus which gradually reopened until the urine reached the umbilicus and escaped. The patient was a male child 13 months old.

The differential diagnosis of polypoid fibroma may be made by having regard to the train of symptoms just stated. It occurs at an earlier age than papillary fibroma, and unlike it, bleeding is not a frequent sign, and when it does occur is only trifling in extent. It may be diagnosed from carcinoma of the bladder, from the fact that the latter is rarely primary, and is attended with the cancerous cachexia—from calculus of the bladder by the introduction of the sound. From hypertrophy of the prostate by the introduction of the finger in the rectum. The prognosis of this affection is most unfavorable as when it is not removed by surgical procedure, a fatal issue invariably occurs from retention of urine and its effects upon the kidneys.

The treatment of tumors of the bladder is palliative and radical. The former consists in administering remedies to allay pain and spasm, the use of the catheter when required and the arrest of hemorrhage when it occurs. Among the earlier operators in these affections was Civiale. He endeavoured to remove them by avulsion and the use of the lithotrite; but his success was not very encouraging. Cystotomy is the only rational method of treating these growths. They may be removed by avulsion, enucleation, ecraseur, or ligation. The fact that the operation has been several times successfully performed should encourage us in its performance whenever suitable cases present themselves. Billroth, after having first verified his diagnosis by opening the bladder through the perineum, divided the recti muscles at their insertion, opened the bladder transversely, and removed the tumor by avulsion. The patient was discharged cured on the 23rd day. Dr. Mass, of Breslau, in 1876, suggested a plan which it would be well to have recourse to before subjecting the patient to a cutting operation. It consisted in pouring water into a double current catheter (with a large eye) inserted in the bladder, in the hope that the out-flow may entangle the growth in the eye of the instrument. In this way he succeeded in three cases in removing small pedunculated mucous polypi. The lithotrite might also be used to remove portions of the growth for examination. In females the short and easily dilated urethra and absence of of the prostate renders access to the tumour tolerably easy of accomplishment and the risk is much less; not unfrequently also the tumor protrudes through the urethra and may be ligated or pulled well down and removed by avulsion. In the case before us, from the nature of the growth and its attachment, an operation would, in all probability, have been attended with success if the diagnosis had been made with certainty sufficiently early, *i. e.*, before the disease had progressed to the stage of ulceration of the bladder. In any similar case occurring under my care in future I should have no hesitation in performing cystotomy with a view to the removal of the growth. The operation has met with a large measure of success in the hands of Sir Henry Thompson and others.

SURGERY OF THE SPINAL CORD.*

BY J. CAMPBELL, M.D, L.R.C.P. ED., SEAFORTH, ONT.

The very interesting and important subject of what now generally goes by the name of "Railway Spine," has, during the last year, been attracting

*Report on Surgery Ont. Med. Association, 1884.

renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years surgeon to one of the greatest railway corporations in England, and, therefore, had a very extended experience of all possible railway injuries, and particularly of cases of so-called "Railway Spine." He contends that cases of what are commonly called "concussion of the spine," do not exist, except in the imagination of the surgeon making the diagnosis. By concussion he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt.

It is well-known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms, spinal symptoms, are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He, at least, conclusively shows that the vast majority of cases of concussion of the spine are nothimg more nor less than cases where the lumbar muscles or ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the other hand, maintains that these so-called cases of spinal concussion always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort.

Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post mortem investigation. The great trouble in coming to an opinion as to the nature and cause of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change, but whether we have to do with an actual or feigned train of symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble, but where he has to do with an intelligent and unscrupulous man who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis.

In the words of a recent writer, the "needed clinical work, it seems to us, in the study of 'railway spine' is the determination of clearly defined types of the disease, and the investigations of the variations from this type, and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of one of our periodicals there is a very instructive case reported, by Dr. Edmunds, of a soldier who was struck in the back with a bullet. He fell immediately, and had to be carried out of action. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured, because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bedsore over the sacrum before death, which occurred five months after the injury. At the autopsy there was no fracture or indication of fracture, or dislocation of the vertebræ to be found. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound, this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts, and above into sclerosis of the posterior columns. There was no indication of hemorrhage, either external or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have from a severe shock sufficient changes brought about in the spinal cord to cause death, and that these changes were in the first place nothing more or less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have tabes dorsalis arise from peripheral causes. That, in fact, an ulcer in the foot may be the *fons et origo mali* of this formidable disease. The origin of the disease in such cases is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

SURGICAL DISEASES OF JOINTS.

BY H. P. YEOMANS, M.D., MT. FOREST.

Report on Surgery, Ont. Med. Association.

In cases of very great distension with continued pain in the later stages of acute or subacute synovitis, Barwell recommends puncture and withdrawal of the fluid. This is accomplished with a sharp small tubular needle, having a rubber tube attached. Pressure is made by an elastic bandage around the knee so as to press out the fluid and prevent the entrance of air. The rubber tube may be filled with a solution of carbolic acid and held above the joint until the puncture is made. After the needle has entered the cavity containing the fluid, the tube may be lowered and its free open end placed in a carbolic solution. By this means tension is relieved, and consequently pain; means must afterwards be adopted to lessen inflammation such as cold, or in some cases heat, etc.

Suppurative synovitis may, after evacuation, be treated by complete rest and thorough drainage. The temperature falls or rises as the pus is retained or thoroughly washed out.

In hip-joint disease rectal examination has been employed in addition to other methods of diagnosis. The symptoms discovered by a rectal examination are pain on pressure upon the os-innominatum behind the acetabulum—enlargement of the intra-pelvic glands, thickening of the bones, depression, flexibility, mobility, or destruction of the post-cotyloidean surface, congestion of the soft parts pelvic abscess—one or other of these symptoms may be found in different stages of the disease.

With regard to treatment, Dr. Hutchinson deprecates the application of any retentive apparatus whatever. The patient wears a high heeled shoe on the sound limb, is provided with a pair of crutches and allowed to go about. He points out "that immobility is secured by reflex contraction of the peri-articular muscles, aided by intracapsular effusion and the voluntary effort to keep the joint at rest on account of the pain which motion produces."

Splints of all kinds allow more or less mobility of the joint and interfere with freedom of the patient in moving about in order to obtain necessary exercise. There appears to be considerable difference of opinion as to the efficiency of all the various appliances and methods of treatment.

Reports of Societies.

MICHIGAN STATE BOARD OF HEALTH.

(Reported for THE CANADA LANCET).

The annual meeting of the Michigan State Board of Health was held in Lansing, Mich., April 14, 1885. All the members were present. The president's address was the first order of business. He congratulated the Board on what it had achieved. He thought it would be well to continue holding sanitary conventions in different places in the State. He spoke of the probable advent of Asiatic cholera, and thought that it might tax the Board to its utmost. The Board had done all it could to prepare to resist the disease, but should be ready for further action. If the bill before the legislature becomes law, the powers of the Board will be increased. He advised police regulations in cities, to prevent unsanitary conditions; and said that health officers of cities, villages and townships, especially those recently appointed to that office, should be instructed in regard to their duties.

The Secretary read a report of the work of the office during the past quarter. Ten thousand copies of the document on the restriction and prevention of contagious diseases were distributed. The Secretary also stated that the outbreak of smallpox at South Boardman had been suppressed.

At the last meeting of the Board, the subject of proposed legislation relative to diseased animals, and also relative to a standard for milk, had been referred to a committee, and bills relating to those subjects had been introduced into the House of Representatives.

The Secretary reported that there had been considerable effort to get the legislature to lower the

standard test for dangerous oils, and to do away with the use of the tester adopted and recommended by this Board. It was claimed that the changes were needed in the interests of small manufacturers. The proposed change would lower the standard about ten degrees. A resolution was passed deprecating the lowering of the test now required for illuminating oils.

The Secretary read the report by Surgeon Geo. M. Sternberg, U.S A., now at John Hopkins University, on his experiments on lower animals in feeding, and in making injections of culture-fluids of poisonous cheese, with the view of learning the nature and source of the poison.

Dr. Vaughan gave a report of his experiments with poisonous cheese. He had secured in a crystalline form a substance from poisonous cheese which would produce in man symptoms common to cheese poisoning. There might be other poisons in poisonous cheese. He had not yet fully studied the poison he had obtained. It gave reactions like those of a ptomaine.

The Board recommended a sanitary survey of the cities and villages in the State, and the adoption of such measures as may be necessary to place them in a good sanitary condition.

Selected Articles.

FORTY YEARS' EXPERIENCE IN MIDWIFERY.*

BY W. SYMINGTON BROWN, M.D., OF STONEHAM, MASS.

The art of midwifery belongs to prehistoric times; the science of obstetrics is the latest recognized of all the ancient sciences. There is no branch of medicine which demands more skill, presence of mind, or justifiable daring than midwifery. It needs a man who can neither be overwhelmed by disaster nor unduly elated by success,—one who who has the courage and honesty to do whatever is best for his patient, irrespective of consequences. Of such men no profession possesses a superfluity.

It is a strange fact, however, that only sixty years ago practitioners in midwifery were not admitted as Fellows to the College of Physicians, London, on the ground of inferiority, and the Royal College of Surgeons did not require candidates for its diploma to undergo an examination in obstetrics. This odium has nearly disappeared in our day, but a single item illustrative of its vestiges may be cited. I refer to the fact that the popular encyclopædias of our own day make no reference to the lives of prominent obstetricians, such as Smellie, Levret, or Naegele. Hundreds of insignificant names are recorded in Appleton's, Chamber's and Johnson's Encyclopædias, but a profound genius like William Smellie—writer, teacher, inventor and artist—is not even mentioned.

During a short visit to Scotland, in 1876, I met a lady, thirty-five years old, at whose birth I officiated obstetrically. And I had attended more than a hundred midwifery cases before that one. I wish I possessed a record of them all. While a medical student I served three years as assistant to the late Dr. James Paterson, Professor of Midwifery in the Andersonian University, and delivered many women among the destitute poor of Glasgow. During the last nineteen years I have kept a moderately full record. The whole number, dating from 1840, must exceed 2,000 cases.

In 1842 forceps were rarely used. It was a period of reaction, and many physicians entertained a strong prejudice against their employment, except in extreme cases. Dr. F. H. Ramsbotham, physician to the Royal Maternity Charity, London, in summing up the symptoms warranting recourse to forceps says: "If the pains have entirely disappeared, if the strength is failing, the spirits sinking, the countenance becoming anxious, if the pulse be 120 or 140 in the minute, the tongue dry, brown, and raspy; if there have been two or three rigors; if there be green discharge; if the head have been locked for four hours, and made no progress for six or eight hours; if the patient be vomiting a dark, coffee-ground-like matter; if there be hurried breathing, delirium, or coldness of the extremities." *then* we may use the forceps—before sending for the undertaker.

I recollect attending one case in Glasgow during a long-drawn-out week. The woman was very poor, and had been compelled during the whole period of gestation to sit from fifteen to eighteen hours a day, winding pirns, in order to earn a bare subsistence. There were no alarming symptoms, but the abdominal muscles seemed to be powerless. I sent for Dr. Paterson, and requested him to help her flagging powers with the forceps, but he declined to do so. The case did not come under any of Ramsbotham's excuses. At last the poor woman got tired of waiting; she sent for a docter with fewer scruples and was instrumetally delivered. This case made a deep impression on my mind, and, in fact converted me to the faith which I hold to-day.

In this paper I propose to state very briefly the principal conclusions I have arrived at under six heads, namely: Forceps, Turning, Ergot, Anæsthetics, Antiseptics, and Craniotomy. Before doing so, however, allow me to make one remark in regard to

* Read before the Obstetrical Soction of the Suffolk District Medical Society, January 21, 1885.

the language employed. Although what follows may appear like laying down the law in a somewhat curt fashion, such is not my intention. What follows are simply my own opinions on certain obstetrical problems colored by the personal medium. Nobody is more anxious than I am to be set right where I have been wrong. The late Dr. J. C. Warren, in his classical work on "Tumors," gives us this good advice: "He (the surgeon) must get the opinion of other surgeons. Even those who have not so much experience as himself may afford him excellent hints, and strike out from his own mind thoughts which without this collision would not have been elicited." Dr. Barnes also truly asserts that "there is no man whose experience is so great that nothing is left for him to learn from the experience of others." Such societies as this one answer that purpose.

FORCEPS.

I prefer curved to straight forceps. They are about as easily applied, and are less liable to slip. If a beginner can only afford one it should be a long pair, either nickel or silver-plated. But it is convenient to own a short pair, and I always carry one in my obstetrical bag, along with a No. 6 gum-elastic catheter (male), a Davidson syringe, a hypodermic syringe, a few feet of flat covered wire (such as milliners use), ether, ergot, chloral and whiskey.

The short forceps may be used at any time when their employment will benefit the patient or her coming child. We should *not* use them merely to save our own time. But the long forceps (when applied within the uterus) should seldom or never be used without a consultation. Indeed, it is a wise precaution, in most difficult or dangerous cases, to call in a brother practitioner to share the responsibility. I make it an invariable rule to pass a soft catheter into the bladder before applying forceps. In some cases using the catheter helps progress, even when forceps are not needed. If the rectum contains solid fæces I also give an enema of warm soapsuds.

How should the forceps be applied? In Scotland the woman is placed on her left side, with her hips projecting from the bed. In this country the the dorsal position is preferred, and it is the one I most frequently use. Lately I have tried a new way, which has certain advantages. The woman lies on her back in the centre of the bed or anywhere, and is not moved at all. Of course, it is not convenient to use long forceps in this position; but, when practicable it avoids the appearance of preparing for a surgical operation, and I think the less fuss we make the better it is for our patient.

In most cases I insert each blade at the side of the pelvis, without regard to the position of the the child's head. If the vertex presents, you can scarcely go wrong by following this rule, and it saves the patient the annoyance of searching for an ear and other annoying manipulations. I make traction only during a pain, and relax pressure when the pain abates. I think it is advisable to pull with a slight pendulum motion, instead of using direct traction, on the same principle that it is easier to pull down a pair of tight pantaloons by drawing on alternate sides than by pulling on both sides at once.

ERGOT.

As a means of shortening labor, ergot is seldom employed nowadays. The forceps have crowded it out of use for that purpose. But as an agent in promoting uterine contraction, after delivery of the placenta, and especially in cases of threatened flooding (some women have a hæmorrhagic idiosyncrasy), it is a valuable remedy. One reason why ergot has fallen into disrepute is the poor quality of many specimens offered for sale. Dr. Squibb's aqueous extract rarely disappoints me. It should be borne in mind, however, that no drug is readily absorbed during extreme depression.

After much blood has been lost our main reliance should be placed on other agencies, such as injections of very hot water and mechanical pressure. The accoucheur's hand inside the womb, with external counter-pressure, is the most reliable method. In milder cases I have succeeded in arresting severe hæmorrhage by injecting hot water and vinegar into the flaccid uterus. But the water must have a temperature of 130° F. in the basin, as it cools during its passage along the tube.

TURNING.

As this operation requires no surgical instrument, it obviously antedates the forceps, and, since the days of Ambrose Paré, has been a favorite with many practitioners, and even with skilled midwives. I was acquainted with a physician who, if one might draw an inference from his usual practice, seemed to think that nature had made a mistake in placing the child upside down in the womb In our own day the late Sir James Simpson, Dr. Barnes, and Dr. Braxton Hicks have done much to bring version into favorable notice. On one occasion, before labor had fairly commenced, while making an external examination, I detected the child's head above the brim, and succeeded in converting a cross presentation into a normal one by the Braxton-Hicks method. I was agreeably surprised at the ease with which the change was effected. But, notwithstanding the plausible arguments advanced by Simpson, Barnes and others, I have come to the conclusion that turning, after the evacuation of the liquor amnii, is a very dangerous operation for the child, and not much safer for the mother. I admit that cases occur where no other alternative (except Cæsarean section) is left us. If we conclude to turn, the operator's left hand should be used, and, in most cases, it is better to bring down one foot than

two feet. The accoucheur's left hand is the obstetrical hand *par excellence*. Physicians should learn to use it adroitly more than they do.

ANÆSTHETICS.

The foremost question under this head is, Do anæsthetics injure the patient? I am pretty sure that they do not. Since 1849 I have used ether, chloroform, or a mixture of the two with alcohol, in every case where the woman was willing to breathe an anæsthetic. Some object; they are afraid to take it, and these I do not urge; but the majority are glad to get it before the labor is over. As a general rule I do not give ether during the first stage.

High authorities tell us that there is a greater tendency to post-partum hæmorrhage after ether or chloroform has been administered. During the last sixteen years I have not employed chloroform in midwifery practice, except as a remedy for convulsions; but I believe that ether, in moderate doses, does not tend to bring on flooding. Ether is seldom given to the extent of unconsciousness. The patient knows what is going on, and can render voluntary assistance when solicited.

A small dose of ether acts beneficially in two ways: it blunts sensibility to pain and allows the abdominal muscles to aid in propulson. Without ether the patient's will-power is instinctively exerted to delay the labor; with it the canal is more likely to be relaxed, and the voluntary muscles are not so much restrained. The contractile power of the womb itself is not affected by moderate inhalation of ether.

ANTISEPTICS.

Cleanliness is a good thing in midwifery, and antiseptics are its aides-de-camp. A young doctor who keeps his nails in mourning will eventually have to mourn the absence of a lucrative practice. Still it is possible to have too much of a good thing. Dr. Thomas, of New York, has recently taken a stand on this subject which most physicians would call ultra. The rules and regulations he lays down might possibly be enforced in a hospital, but hardly in private practice. And even if they could be carried out, I question the advantages of trying to surround a physiological process with all the paraphernalia needed in a surgical operation. Carbolic acid has had its flood-tide, and begins to ebb. Corrosive sublimate will probably follow suit at no distant day. Please observe, I do not object to disinfectants or antiseptics in themseves. Both of the chemicals mentioned will no doubt, be used occasionally with advantage. But I believe that carbolic acid nearly killed Dr. Thomas Keith, and not a few unfortunate patients have suffered from its wholesale reckless employment. I greatly prefer a weak solution of iodine, prepared with iodide of potassium, which may be diluted with water without precipitation, or a hot solution of permanganate of potas. In ordinary cases absolute cleanliness is all that is needed. The routine employment of vaginal injections is likely to do more harm than good. I concur in the opinions expressed by Dr. Adams, of Framingham, in his interesting paper read at your last meeting. Dr. William Godell's suggestion that lying-in women should be encouraged to assume the erect posture ealy, with a view to facilitate the removal of clots and *débris*, is an excellent one.

As already hinted, it is a good plan for the obstetrician to wash his hands, keep his finger nails pared pretty close, and to fill the small remaining space with softened soap before making a vaginal examination. A Syracuse æsthetic M.D. kindly suggests that no harm would result if he also washed his hands afterward.

CRANIOTOMY.

During the last nineteen years I have performed craniotomy three times, all of the cases occurring in the practice of other physicians. No operation tries a surgeon's nerve more than this one. When we are sure that the child is dead, of course it is plain sailing. But there are cases when the fœtal heart cannot be distinctly heard, and yet the child is alive. To plunge a perforator into a living child's skull, and deliberately take its life, with the view to save that of its mother, is, to say the least, a sad alternative. I hope I shall never feel compelled to do it again. In these days of successful abdominal surgery, would we not be justified in appealing to the patient to allow us to perform the Cæsarean section or laparoëlytrotomy? But we should not wait till the woman is at death's door before operating. In this, as in all other life-saving operations, promptness and decision win the day.

The medical profession is deeply indebted to Dr. Thomas for his efforts to popularize laparoëlytrotomy. I understand that he tried the operation several times on the cadaver before performing it on a patient. Nearly all great surgeons have been in the habit of doing this. In this case the principal difficulty will be to get the consent of the patient and her friends in season to be of any service. We all love to put off the evil day, or even the evil hour, and so the golden opportunity slips through our fingers. But as successful results in this line increase the dread of the operation itself will decrease, and obstetric surgery may achieve a new triumph in the salvation of human life.—*Boston Med. & Surg. Journal.*

SUGGESTIONS FROM DISPENSARY EXPERIENCE, FOR THE SURGERY OF GENERAL PRACTICE.

BY DR. C. W. DULLES, PHILADELPHIA.

It has often seemed to me that the experience gained in the many dispensaries of our large cities

is not made of as much service to the profession as it might be, and that it would not be amiss if those who have the advantages which these positions afford would occasionally try to put into accessible shape the lessons which they have there learned, and lay them before their brethren for adoption or correction. And, because I have had to learn by experience some things which it would have been better for my patients if I had found out in some other way, I have thought it might be worth while for me to invite your attention to certain notions in regard to the kind of surgery which occurs in general practice, which I have gathered during the past ten years, and which, if they are correct, may be helpful to others; if they are incorrect, I shall be glad to have them criticised.

I. THE DIAGNOSIS OF SURGICAL LESIONS.

I trust I shall not be deemed officious in urging the importance of thoroughness and discernment in making up a diagnosis as to what is the nature of the lesion for which one is consulted by a sufferer. Every writer, and every lecturer, dwells, more or less, upon this point. But, in spite of all that is said and written, mistakes are constantly being made, which greater care would have prevented. I have seen fractures treated as contusions, and contusions as fractures, over and over again. I have seen a patient treated for a fracture at the lower end of the radius with a time-honored Bond's splint, who had nothing the matter near the wrist, but who had a severe and dangerous contusion of the elbow-joint. I have seen hydroceles treated for years as herniæ, and have been called to operate for strangulated inguinal hernia when there was only a hydrocele of the cord, innocent and easy to cure. I have seen a psoas abscess mistaken for a hernia, and over and over again sinuses of the face, due to disease of the root of a tooth, treated in vain as simple abscesses, the recognition of the cause and the removal of the offending tooth being followed by a prompt recovery. I do not care to cite many mistakes of my own, but I cannot forget my mortification once when caught napping by an ulcerated knee, the syphilitic nature of which was indicated and easily demonstrated when a more experienced surgeon asked to see the other leg. On the other hand, I have known lesions to be characterized as syphilitic on what I thought to be an unwarrantable suspicion, and a cross-examination to show that what a patient called a chancre could not possibly have been the initial lesion of syphilis. Now, such errors should not be passed over, or hushed up, when we are speaking among ourselves, or we shall miss the advantage of being taught the necessity for constant vigilance and thoroughness in examining our patients. Of course, this is not the place to discuss the diagnosis of various lesions; but it may be worth while to call attention to the importance of making our examination include, not only the part believed by the patient to be injured, but also the surrounding parts—muscles, bones or joints, as the case may be—for some distance above and below. The opposite and corresponding parts should often be looked at, for purposes of detection or comparison. Nor should we hesitate to call to our aid the probe or the exploring needle, both of which are valuable and harmless instruments in judicious hands. Two little points, in regard to the sinuses of the face, I would like to speak of. One is the well enough advocated examination of the teeth, by inspection and tapping, to detect a state of abscess in the alveolus; the other I do not remember to have seen recommended. This is, to test a suspected salivary fistula by bringing a drop of the discharge into contact with a drop of the tincture of chloride of iron on a white surface—a piece of white paper will do—when, if the discharge contain saliva, it will give the pink color which indicates the presence of the sulphocyanide of potassium, a normal ingredient of saliva. And, before dismissing this subject, I think a word may be said as to the failure, when one is really at a loss, to get the opinion of some one who is more familiar with our subject than we are. However proper the motives may appear which lead to this, they cannot avert from the patient the consequences of error or delay in diagnosis or treatment; and I believe it would be greatly to the advantage of our patient and ourselves, if we accustomed them to the idea of having a consultation before a case becomes extreme.

2. THE CLEANSING OF WOUNDS.

My own experience has led me to the belief that this salutary proceeding is sometimes overdone. When we see a scalp-wound, or a laceration of the face, covered with a scab, even though it be not a very handsome one, good surgery does not, I think, require us to take it off, unless the appearance of the neighboring parts indicates that an inflammatory process is going on under it. Nor, when a crushed finger is enveloped in dry covering of blood and machinery grime, need we think our patient's safety depends upon a thorough removal of these. On the contrary, I should say his rapid recovery often depends upon our letting them alone. But scabs that cover pus may always be removed with advantage; and foul secretions, or accumulations, can only do harm, and must be cleaned out. So the cleansing of wounds is not only an æsthetic, but also a salutary, procedure. As to the method of cleansing, I am a convert to the views of Mr. Sampson Gamgee, who never uses a liquid for cleansing when it is not specially indicated. Careful mopping with dry cotton or lint will do far more than those who have not tried it would imagine. Rubbing is rarely called for, but just touching with the cotton or lint, and pressing it down with more or less firmness, as the circumstances require. But, when the case demands it,

we must not hesitate to rub firmly, even a little roughly, or to pick off or cut off what sticks tight to the healthy tissues. However, we should not eschew the use of water too tenaciously. It is often indispensable, and, combined with a little permanganate of potash—just enough to make a transparent, pink solution—it is a *sine qua non* in dispensary practice, as a disinfectant and deodorant. This combination, it seems to me, excels every other so-called antiseptic; and carbolic acid, I may say, I never use as an antiseptic at all. In this connection, I wish to emphasize what I think is a very important matter in washing of wounds and sores, namely, that the same fluid should never be used twice; that is, it should not be dipped from a basin and allowed to flow from the wound or sore into the same vessel, and then dipped up and used again, and so on. The best way of washing a wound would be to let the water run upon it from a hose with a regulated force. But almost, if not quite, as good as this, is the plan of having one vessel to hold the wash and another to catch the drippings, and to apply the wash by letting it fall in a steady stream from a clean sponge or a mass of oakum. The size of this stream, and its force, can be easily regulated by the force with which the sponge or oakum is squeezed, and the height at which it is held. If the dripping mass be grasped in the hand and held with the thumb up, by well-regulated squeezing a single stream can be made to fall from the dependent portion in exactly the place and way we wish.

3. THE CONTROL OF HEMORRHAGE.

An important part of the preparation of a wound for dressing, is the control of hemorrhage—I do not mean the hemorrhage from large vessels, but that from small ones, such as are usually encountered in the surgery of general practitioners. Our colleague, Dr. Roberts, has, I think wisely, deprecated the routine use of styptics, and I quite agree with him that, for almost all small vessels, the pressure of a well-applied dressing will do all that is needed in the way of controlling hemorrhage. Such a dressing may be made of dry lint, bound on with moderate firmness —actual tightness is not called for—and often one will have, in a little while, an imitation of nature's favorite method of healing, by the formation of a scab, made up of dried blood and the tissue of the dressing. The essentials for controlling moderate hemorrhage are dry dressings and moderate compression. Pressure alone is sufficient to control the bleeding from scalp-wounds, which are sometimes spoken of as if they were troublesome to deal with. It is remarkable, at times, to hear men describe the pains they have been at to ligate an artery of the scalp, in view of the fact that this is never indispensable. A compress and a bandage will control any vessel in the scalp, and almost anywhere else; and, if an unruly patient is likely to pull a bandage off, a pin, even a common one, may be thrust under the vessel and brought out again beyond it, so as to hold it as long as any one could wish. If still greater security be desired, it can be had by adding a "figure 8" to this pin. And here I wish to add a word as to the need for stopping bleeding. I will go a little further than Dr. Roberts in regard to the innocence of hemorrhages which sometimes cause great uneasiness. Many of these hemorrhages are absolutely beneficial. Of course, one need not be foolhardy; but such hemorrhages as come from superficial wounds may be regarded with the greatest equanimity, and no one need get flustered in trying to stop them. In my own experience, I often encourage bleeding to a considerable extent, as in the case of incisions for felons and palmar abscesses, and the like, and have never felt that I lost anything by being deliberate. Hemorrhage from small vessels can often be controlled by a firm pinch with the forceps, or the vessel may be drawn out and twisted round several times. This will often obviate the necessity for ligatures, in operations such as circumcision of infants or children. Sometimes the arteries in the fingers will bleed in a most troublesome way. If the bleeding cannot be stopped by pressure or torsion, it can be controlled by a pad of lint and a few circular turns of adhesive plaster. Persistent hemorrhage from an alveolus, in one with a hemorrhage diathesis, I have controlled, when plugging gave only temporary relief, by injecting a fine stream of cool water against the bleeding point. Bleeding from the wound of the palmar arch can, I believe, almost always be controlled by a pad and bandage.

4. DRESSING OF WOUNDS.

Dry Dressing.—Nature's method of protecting wounds is by the process of scabbing; and when we reflect upon the successful way in which this operates in all the lower animals, and often in man, too, we may wonder that it should be almost a matter of routine to remove scabs in surgical practice. It may gratify our curiosity, it may even aid our study at times, but it is often of no advantage to the patient to remove from a disfigured face, or a cut head, the crusts which are nature's reliable antiseptic dressings. From what I have seen, I believe it is best to leave such crusts undisturbed whenever possible, and if they are objectionable, in an æsthetic sense, simply to cover them with something better looking. Further, it may be said that an artificial scab made with lint, or tarletan, or thin muslin, and collodion, forms one of the best dressings for simple incised and not a few lacerated wounds, which have ever been devised. In hospital practice, I see many cut heads and simple incised wounds, even after the removal of tumors, which go to a prompt and uninterrupted healing under the first dressing of this sort. Similarly, scabs may be formed by allowing lint to become saturated with the oozing of a wound exposed to

the air. Dry powders, such as earth or bismuth, or calomel, or powdered borax, or boric acid, or iodoform, may also be used to promote the formation of a crust. In all these cases, however, it is important to watch lest the crust bind down offensive discharges, as any scab may do; when this happens, the crust must, of course, be removed, and the wound cleaned. In the case of strumous ulcers and the weak granulations of large burns, I have had the happiest results from setting aside ordinary dressings, and applying a powder in this way. In these latter cases, I have sometimes practiced exposure of the granulating surface to the air until the serous film covering them has coagulated and formed a species of skin over them. And to my astonishment, I have seen such a film actually transformed into thin skin without displacement. This is a fact which I believe does not accord with the accepted laboratory idea of new skin formation; but it is a fact, nevertheless. And I would especially urge upon others this plan of treatment in the class of cases referred to —old burns and strumous ulcers—which are, I believe, often kept open by the ointments and other warm and moist dressings used to promote their healing.

Water Dressing is another good dressing, which I believe is too little appreciated. I have seen a number of wounds of the fingers and hands, for example, done by machinery, in which rapid and painless recovery has followed the application of wet lint, which was wetted again as often as convenient, with a lukewarm or cool solution of common borax. Patients with such injuries I have often dressed with cold water, and told them to dip the finger or hand, as the case might be, in a solution of a teaspoonful of powdered borax in a pint of water, warm or cool, as they found more pleasant, without removing the first dressing.

Lead-water and Laudanum is but little better than cold water, so far as my experience would indicate; although it is suited to cases that are especially hot and painful. But I believe this ought never to be covered up, as it very often is, with impervious coverings. It is not an uncommon thing for me to see a cut hand, or a contused joint, or a painful fracture, covered with lint soaked in lead-water and laudanum, with a piece of waxed paper over this, and next a bunch of oakum, the whole bound to a splint with many layers of bandage. My inquiries have usually elicited, from patients treated in this way, the most expressive assurances that they had suffered much, often having passed a sleepless night after these dressings were applied; and I have, I think I may say invariably, found that the suffering disappeared when I changed the dressing for a light lint, dipped in lead-water and laudanum, and held in place by a thin, light bandage, so applied as to leave part of the lint exposed to the air and consequently to evaporation of the lotion, with no splint at all, or the lightest and smallest kind possible. What makes a recent injury hot and air-proof, I have found usually a painful dressing.

Dilute Alcohol is another refreshing dressing, if it be allowed to evaporate, and removed at the first sign of pain.

Carbolized Oil, which is, perhaps, not such a very common surgical dressing nowadays, I have found to become very quickly offensive, and I now hardly ever use it. If renewed often enough, it is, however, soothing and healing.

Ointments.—To discuss fully the ointments in use in simple surgery, would require more time than you have to give me. So I may, perhaps, be justified in stating that the most universally applicable ointment for open wounds which I know of, is one made of equal parts of carbolic acid ointment and oxide of zinc ointment. This has seemed to me to do more good than any other ointment in the case of granulating surfaces, unless they were syphilitic, and in these, I think, mercurial ointments sometimes do better. A little point in regard to the use of ointments is, that they should be confined, as nearly as possible, to the open surface. A piece of lint or muslin should be spread with the ointment, and trimmed down to the exact size of the sore. If spread on the adjacent skin, it will often, after a while, set up an artificial eczema, which is very annoying to a patient.—*Med. & Surg. Reporter.*

STANDARD DISINFECTANTS.

Disinfection of Excreta, etc.—The infectious character of the dejections of patients suffering from cholera and from typhoid fever is well established; and this is true of mild cases and of the earliest stages of these diseases as well as of severe and fatal cases. It is probable that epidemic dysentery, tuberculosis, and perhaps diphtheria, yellow fever, scarlet fever, and typhus fever may also be transmitted by means of the alvine discharges of the sick. It is therefore of the first importance that these should be disintected. In cholera, diphtheria, yellow fever,and scarlet fever, all vomited material should also be looked upon as infectious. And in tuberculosis, diphtheria, scarlet fever, and infectious pneumonia, the sputa of the sick should be disinfected or destroyed by fire. It seems advisable also to treat the urine of patients sick with an infectious disease with one of the disinfecting solutions below recommended.

Chloride of lime, or bleaching powder, is, perhaps, entitled to the first place for disinfecting excreta, on account of the rapidity of its action. The following standard solution is recommended:

STANDARD SOLUTION No. 1.

Dissolve chloride of lime of the best quality in

soft water, in the proportion of four ounces to the gallon.

Use one pint of this solution for the disinfection of each discharge in cholera, typhoid fever, etc. Mix well, and leave in vessel for at least ten minutes before throwing into privy-vault or water-closet. The same directions apply for the disinfection of vomited matters. Infected sputum should be discharged directly into a cup half full of the solution.

STANDARD SOLUTION NO. 2.

Dissolve corrosive sublimate and permanganate of potash in soft water, in the proportion of two drachms of each salt to the gallon.

This is to be used for the same purposes and in the same way as Standard Solution No. 1. It is equally effective, but it is necessary to leave it for a longer time in contact with the material to be disinfected—at least an hour. The only advantage which this solution has over the chloride of lime solution consists in the fact that it is odorless, while the odor of chlorine in the sick-room is considered by some persons objectionable. The cost is about the same. It must be remembered that this solution is highly poisonous. It is proper, also, to call attention to the fact that *it will injure lead pipes if passed through them in considerable quantities.*

STANDARD SOLUTION NO 3.

To one part of Labarraque's Solution (liquor sodæ chlorinatæ) add five parts of soft water.

This solution is more expensive than the solution of chloride of lime, and has no special advantages for the purposes mentioned. It may, however be used in the same manner as recommended for Standard Solution No. 1.

The following powder is also recommended for the disinfection of excreta in the sick-room and of privy-vaults, etc. :

DISINFECTING AND ANTISEPTIC POWDER.

One pound of chloride of lime ; one ounce of corrosive sublimate ; nine pounds of plaster of Paris. Pulverize the corrosive sublimate and mix thoroughly with the plaster of Paris. Then add the chloride of lime and mix well. Pack in paste-board boxes or in wooden casks. Keep dry.

As an antiseptic and deodorizer this powder is to be sprinkled upon the surface of excreta, etc.

To disinfect excreta in the sick-room, cover the entire surface with a thin layer of the powder—one-fourth inch in thickness—and if the material is not liquid pour on sufficient water to cover it.

Disinfection of the Person.—The surface of the body of a sick person, or of his attendants, when soiled with infectious discharges, should be at once cleansed with a suitable disinfecting agent. For this, Standard Solution No. 3 may be used.

In diseases like small-pox and scarlet fever, in which the infectious agent is given off from the entire surface of the body, occasional ablutions with Labarraque's Solution, diluted with twenty parts of water, will be more suitable that the strong solution above recommended.

In all infectious diseases the surface of the body of the dead should be thoroughly washed with one of the standard solutions above recommended, and then enveloped in a sheet saturated with the same.

Disinfection of Clothing.—Boiling for half an hour will destroy the vitality of all known disease germs, and there is no better way of disinfecting clothing or bedding which can be washed than to put it through the ordinary operations of the laundry. No delay should occur, however, between the time of removing soiled clothing from the person or bed of the sick and its immersion in boiling water, or in one of the following solutions ; and no article should be permitted to leave the infected room until so treated.

STANDARD SOLUTION NO. 4.

Dissolve corrosive sublimate in water in the proportion of four ounces to the gallon, and add one drachm of permaganate of potash to each gallon to give color to the solution.

One fluidounce of this standard solution to the gallon of water will make a suitable solution for the disinfection of clothing. The articles to be disinfected must be thoroughly soaked with the disinfecting solution and left in it for at least two hours, after which they may be wrung out and sent to the wash.

Solutions of corrosive sublimate should not be placed in metal receptacles, for the salt is decomposed and the mercury precipitated by contact with copper, lead, or tin. A wooden tub or earthen crock is a suitable receptacle for such solutions.

Clothing may also be disinfected by immersion for two hours in a solution made by diluting Standard Solution No. 1 with nine parts of water —one gallon in ten. This solution is preferable for general use, especially during the prevalence of epidemics, on account of the possibility of accidents from the poisonous nature of Standard Solution No. 4. When diluted as directed this solution may, however, be used without danger from poisoning through the medium of clothing immersed in it, or by absorption through the hands in washing. A poisonous dose could scarcely be swallowed by mistake, owing to the metallic taste of the solution, and the considerable quantity which would be required to produce a fatal effect—at least half a pint.

Clothing and bedding which cannot be washed, may be disinfected by exposure to dry heat in a properly constructed disinfecting chamber for three or four hours. A temperature of 230° F. should be maintained during this time, and the clothing must be freely exposed—*i. e.*, hot folded or arranged in piles or bundles, for the penetrating power of dry heat is very slight.

The limitations with reference to the use of dry heat as a disinfectant are stated in a "Preliminary Report of the Committee on Disinfectants," published in the *Medical News*, March 14, 1885.

The temperature above mentioned will not destroy the *spores* of bacilli—*e. g.*, of the anthrax bacillus, but is effective for the destruction of all disease germs which do not form spores; and there is good reason to believe that this list includes small-pox, cholera, yellow fever, diphtheria, erysipelas, puerperal fever, and scarlet fever (?) Moist heat is far more effective, and it is demonstrated that ten minutes exposure to steam, at a temperature of 230 F., will destroy all known disease germs, including the most refractory spores.

In the absence of a suitable disinfecting chamber, it will be necessary to burn infected clothing and bedding, the value of which would be destroyed by immersion in boiling water, or in one of the disinfecting solutions recommended.

Disinfection of the Sick-room.—In the sick-room no disinfectant can take the place of free ventilation and cleanliness. It is an axiom in sanitary science that *it is impracticable to disinfect an occupied apartment;* for the reason that disease germs are not destroyed by the presence in the atmosphere of any known disinfectant in respirable quantity. Bad odors may be neutralized, but this does not constitute disinfection in the sense in which the term is here used. These bad odors are, for the most part, an indication of want of cleanliness, or of proper ventilation; and it is better to turn contaminated air out of the window, or up the chimney, than to attempt to purify it by the use of volatile chemical agents, such as carbolic acid, chlorine, etc., which are all more or less offensive to the sick, and are useless so far as disinfection—properly so-called—is concerned.

When an apartment which has been occupied by a person sick with an infectious disease is vacated, it should be disinfected. But it is hardly worth while to attempt to disinfect the atmosphere of such an apartment, for this will escape through an open window and be replaced by fresh air from without while preparations are being made to disinfect it. Moreover, experience shows that the infecting power of such an atmosphere is quickly lost by dilution, or by the destruction of floating disease germs through contact with oxygen, and that even small-pox and scarlet fever are not transmitted to any great distance through the atmosphere; while cholera, typhoid fever, and yellow fever are rarely, if ever, contracted by contact with the sick, or by respiring the atmosphere of the apartments occupied by them.

The object of disinfection in the sick-room is, mainly, the destruction of infectious material attached to surfaces, or deposited upon window-ledges, in crevices, etc. If the room has been properly cleansed and ventilated while still occupied by the sick person, and especially if it was stripped of carpets and unnecessary furniture at the outset of his attack, the difficulties of disinfection will be greatly reduced.

All surfaces should be thoroughly washed with a solution of corrosive sublimate of the strength of one part in 1000 parts of water, which may be conveniently made by adding four ounces of Standard Solution No. 4 to the gallon, or one pint to four gallons of water. The walls and ceiling, if plastered, should be whitewashed with a lime wash containing the same proportion of corrosive sublimate, or they may be brushed over with the aqueous solution. Especial care must be taken to wash away all dust from window-ledges and other places where it may have settled, and to cleanse thoroughly crevices and out-of-the-way places. After this application of the disinfecting solution, and an interval of twenty-four hours or longer for free ventilation, the floors and wood-work should be well scrubbed with soap and hot water, and this should be followed by a second more prolonged exposure to fresh air, admitted through open doors and windows.

Many sanitary authorities consider it necessary to insist upon fumigation with sulphurous acid gas—produced by combustion of sulphur—for the disinfection of the sick-room. As an additional precaution, this is to be recommended, especially for rooms which have been occupied by patients with small-pox, scarlet fever, diphtheria, typhus fever, and yellow fever. It should precede the washing of surfaces, and free ventilation above recommended. But fumigation with sulphurous acid gas alone, as commonly practised, cannot be relied upon for the disinfection of the sick-room and its contents, including bedding, furniture, infected clothing, etc., as is popularly believed. And a misplaced confidence in this mode of disinfection is likely to lead to a neglect of the more important measures which have been recommended. In the absence of moisture the disinfecting power of sulphurous acid gas is very limited, and under no circumstances can it be relied upon for the destruction of spores. But exposure to this agent in sufficient quantity, and for a considerable time, especially in the presence of moisture, is destructive of disease germs, in the absence of spores. It is essential, however, that the germs to be destroyed shall be very freely exposed to the disinfecting agent, which has but slight penetrating power.

To secure any results of value, it will be necessary to close the apartment to be disinfected as completely as possible by stopping all apertures through which the gas might escape, and to burn not less than three pounds of sulphur for each thousand cubic feet of air-space in the room. To secure complete combustion of the sulphur it should be placed, in powder or in small fragments, in a shallow iron pan, which

should be set upon a couple of bricks in a tub partly filled with water, to guard against fire. The sulphur should be thoroughly moistened with alcohol before igniting it.

Disinfection of Privy-vaults, Cesspools, etc.—When the excreta—not previously disinfected—of patients with cholera or typhoid fever, have been thrown into a privy-vault this is infected, and disinfection should be resorted to as soon as the fact is discovered, or whenever there is reasonable suspicion that such is the case. It will be advisable to take the same precautions with reference to privy-vaults into which the excreta of yellow fever patients have been thrown, although we do not definitely know that this is infectious material. Disinfection may be accomplished either with corrosive sublimate, or with chloride of lime. The amount used must be proportioned to the amount of material to be disinfected.

Use one pound of corrosive sublimate for every five hundred pounds—estimated—*of fecal-matter contained in the vault, or one pound of chloride of lime to every thirty pounds.*

Standard Solution No. 4, diluted with three parts of water, may be used. It should be applied—the diluted solution—in the proportion of one gallon to every four gallons—estimated—of the contents of the vault.

If chloride of lime is to be used, one gallon of Standard Solution No. 1 will be required for every gallon—estimated—of the material to be disinfected.

All exposed portions of the vault, and the woodwork above it, should be thoroughly washed down with the disinfecting solution.

To keep a privy-vault disinfected during the progress of an epidemic, sprinkle chloride of lime freely over the surface of its contents daily. Or, if the odor of chlorine is objectionable, apply daily four or five gallons of Standard Solution No. 2, which should be made up by the barrel, and kept in a convenient location, for this purpose.

Disinfection of Ingesta.—It is well established that cholera and typhoid fever are very frequently, and perhaps usually, transmitted through the medium of infected water or articles of food, and especially milk. Fortunately we have a simple means at hand for disinfecting such infected fluids. This consists in the application of heat. *The boiling temperature maintained for half-an-hour kills all known disease germs.* So far as the germs of cholera, yellow fever, and diphtheria are concerned, there is good reason to believe that a temperature considerably below the boiling point of water will destroy them. But, in order to keep on the safe side, it is best not to trust anything short of the boiling point (212° F.) when the object in view is to disinfect food or drink which is open to the suspicion of containing the germs of an infectious disease.

During the prevalence of an epidemic of cholera it is well to boil all water for drinking purposes. After boiling, the water may be filtered, if necessary, to remove sediment, and then cooled with *pure* ice, if desired.

A sheet of filtering paper, such as druggists use, and a glass or tin funnel, furnish the best means for filtering water on a small scale for drinking purposes. A fresh sheet of paper is to be used each day.—*Med. News.*

A NEW TREATMENT OF SCIATICA.

Every physician in general practice must have at different times realized how unsatisfactory are all the modes of treating sciatica. Anodynes have failed, or are required in doses so large and frequent as to be a source of danger to the patient. All the machinery of the revulsive medication, from rubefacient terebinthine liniments to linear vesication, the actual cautery, or punctiform (Paquelin) cauterizations, have been brought to bear upon the suffering member. Electricity in all its forms has been tried and frequently proved disappointing. Local anodynes (solutions of menthol, belladonna, ether spray, chloroform) may have rendered some fleeting service. The general tone of the organism has been fortified by quinine, and the quality of the blood improved by iron and cod-liver oil, but the vitality of the *locus minoris resistentiæ* (that "greatest and worst nerve of the body," as we have heard patients say) still remains depressed. Anti-rheumatics have been tried from salicylate of sodium to colchicum and iodide of potassium, all to the point of tolerance, but all to little effect. Nerve-stretching remains, but that somewhat delicate and difficult operation has been reserved as a last resort. In view, then, of the want of success which has attended the old methods, a new method of treatment which promises comfort to physician and patient will be welcomed.

Devobe has lately proposed refrigeration by chloride of methyl in sciatica, as a medication of singular efficacy. This substance, which is obtained by distilling together methyl alcohol, sodium chlorate, and sulphuric acid, is a colorless gas, slightly soluble in water, with sweetened taste and odor; when projected on a part of the body from a suitable siphon bottle, it is attended with the production of intense cold, followed by intense smarting, and if the action be sufficiently prolonged, considerable erythema and even vesication. The benefit which is claimed from this remedy would seem to be due not so much to the refrigerant as to the subsequent counter-irritant and vesicant effect. Debove, in a late number of the *Bulletin Général de Thérapeutique*, thus explains the principle and *modus operandi* of his method:—

"When we employ revulsion under any form

whatever (vesication, punctiform cauterization, etc.) for a neuralgic affection, we act on certain of the sensory extremities of the painful nerve, but we respect a far greater number of these nerve terminations because it is not possible to multiply to any great extent our vesicatories and cautery points. A process of revulsion which may be extended to the totality of the member innervated by the affected nerve will be then of far greater efficacy. This process I have realized in employing, as a revulsive, *congelation*. To this end I have had recourse to chloride of methyl, which is readily obtainable in commerce, and with which you may produce a speedy refrigeration. I practise with this agent, using for the purpose a siphon bottle furnished with suitable stop-cock and beak, pulverizations along the diseased nerve, directing the spray especially upon the *points douleureux*. This spraying ought not to last longer than a few minutes. It is much less disagreeable than the actual cautery, and (what is more important) *it is followed by instantaneous relief of pain*. I have by this means cured patients who long had been sufferers, and who had obtained only partial relief from other revulsives. Ordinarily one séance suffices to cause the pain to completely disappear; sometimes, nevertheless, a second séance is necessary; but always after the first séance the pains are considerably lessened. When you prolong the spraying a little too long, you produce vesication. Although this is an accident of little importance, I think it better to guard against it, and as a precautionary guide, I habitually consult the feelings of the patient; when they tell me that the sensations which they experience resemble the pain which the punctiform cautery would occasion, I cease the pulverization."

This mode of treatment was lately discussed at a meeting of the Academy of Medicine. Desnos reported four cases of sciatica in which this method was tried; in three it was completely successful. The spraying from a siphon bottle was performed with great precautions, occupying only a few seconds. Rendu has found that a liability to the production of eschars follows the careless or too free use of this new medication: nevertheless, in one or two stubborn instances the most gratifying amelioration, and even cure, resulted. Bucquoi finds the methyl chloride a revulsive rather than an anodyne; in one rebellious case in his practice it was signally beneficial. Sevestre claims to have cured one inveterate case of sciatica after daily applications for two months of the methyl spray. Legroux has also found spraying with this substance useful in the intercostal neuralgias of tuberculosis. Robin, in December, obtained a striking cure by this means, in a patient forty years of age who had for six months suffered from sciatica with atrophy of the limbs; he was cured after two applications of the methyl, which were followed by vesication and intense pigmentation of the congealed region. Letulle has treated two patients by the same process; the one was affected with sciatica from neuritis, and was completely cured; the other, who was suffering from Pott's disease, complained constantly of diffuse lumbar pains, and derived the greatest benefit from the methyl-chloride spray.

It is to be hoped that the favorable experiences of these French practitioners with this new remedy may be followed by equally good results in this country, and that this painful, inveterate malady may become less of an opprobrium to medicine and surgery.—*Boston Med. Journal.*

HEAT AS A DISINFECTANT.

Dr. George H. Rohe gives the following in the *Medical News* regarding dry heat as a disinfectant: The first accurate observations on the disinfecting power of dry heat were made by Henry, of Manchester, in 1831. (Quoted in E. Vallin: *Traite des désinfectants*, Paris, 1882, p. 226). Henry exposed (fresh?) vaccine virus to temperatures varying from 50° to 82° Cent. (122°–180° Fahr.) for two, three, and four hours, and secured complete disinfection, none of the specimens of vaccine thus exposed producing vaccinia when subsequently inoculated. Exposure for three hours to a temperature of 49° C. (120 F.) failed to disinfect. No contra experiments with non-disinfected virus was made by this observer.

E. B. Baxter *Report Medical Officer of Privy Council*, etc., N. S., No. vi., p. 216) exposed dry vaccine to a temperature of from 90°–95° C. (194°–203° F.) for thirty minutes. Disinfection was complete. Vaccination with disinfected virus was unsuccessful. Contra inoculations with non-disinfected virus were successful.

Koch and Wolfhügel (*Mitt. a. d. Kais. Gesundheitsamte*, Bd. I.) experimented with a large number of pathogenic and non-pathogenic organisms. A temperature varying from 78°–123° C. (172°–253° F.) maintained for one hour and a-half (over 212° F. for an hour) sufficed to kill micrococcus prodigiosus and the bacilli of septicæmia of mice and rabbits, but failed to destroy the spores of bacillus anthracis and of various non-pathogenic bacteria and fungi. Micrococci and bacilli containing no spores, and spores of mould fungi, were completely killed by one and a-half hour's exposure to a temperature of from 120°–128° C. (248°–262° F.); but spores of B. subtilis, B. anthracis, and of a bacillus growing upon potato, resisted a second heating to the same temperature for a similar length of time.

These authors further experimented upon a number of organisms disposed in various ways in the disinfecting chamber, so as to approach in a measure the conditions of practical disinfection. Some of the articles were placed in coat pockets,

others rolled up in balls of cotton, oakum, blankets, or soiled clothing, making packages of different thickness and density. The organisms consisted of micrococcus prodigiosus, micrococcus of blue pus, bacillus anthracis, and bacilli found in garden soil. With each package was placed a registering thermometer to indicate the highest temperature reached during the experiment. The temperature in the chamber varied from 133° to 156° C. (271° -313° F.), and the exposure was continued for three hours and ten minutes. The temperatures in the different packages varied from 74.5° C. (167° F.) to 121.5° C. (251° F.). In none of the packages were the spore-bearing organisms destroyed. In a small iron vessel hanging free in the chamber and containing specimens of the same organisms, a temperature of 139.5° C. (283° F.) was indicated by the thermometer. Here complete disinfection had taken place.

Another series of observations with the temperature in the chamber varying from 131°-140° C. (267°-284° F.), and exposure continuing for three hours, resulted as follows: The organisms (micrococcus prodigiosus, spores of bacillus anthracis, and of bacilli of garden soil) and registering thermometers were enclosed in packages of clothing, bedding, and rolls of blankets. Complete destruction of the spore-bearing organisms did not follow unless the temperature of 139° C. (282° F.) had been reached. In one large package consisting of nineteen blankets, thoroughly dried and rolled up, the heat did not penetrate to the interior in a sufficiently high degree to destroy the vitality of micrococcus prodigiosus even.

He submits the following conclusions:

1. A temperature of 100° C. (212° F., dry heat), maintained for one hour and a-half, will destroy bacteria which do not contain spores.

2. Spores of mould-fungi require for their destruction in hot air, a temperature of from 110° -115° C. (230°-230° F.) maintained for one hour and a-half.

3. Bacillus spores require for their destruction in hot air a temperature of 140° C. (284° F.), maintained for three hours.

4. In dry air the heat penetrates objects so slowly that small packages, such as a pillow or small bundle of clothing, are not disinfected after an exposure of from three to four hours, to a temperature of 140° C. (284° F.).

5. Exposure to a temperature of 140° C (284° F.) in dry air for a period of three hours injures most objects requiring disinfection (clothing, bedding, etc.) to a greater or less degree.

MARTIN'S METHOD OF TREATMENT OF SYNOVITIS, ESPECIALLY OF THE KNEE-JOINT.—During the past thirty-one years over four hundred cases of synovitis of the knee and its sequelæ, of every form and degree of severity, in every variety of diathesis and complication, however chronic or acute, have been treated by the use of the pure rubber or "Martin" bandage—applied to the limb from the foot to above the knee. The joint is previously strapped from three inches above to a corresponding point below the patella, with non-irritating rubber plaster. This strapping is not applied for the ordinary reasons, but to obviate, or at least mitigate, a troublesome chafing of the skin in the popliteal space, from walking exercise while the bandage is on the limb. One such strapping will remain *in situ* for four or five weeks, and in a very large proportion of cases has not to be repeated. The plaster, however, must be perfectly non-irritating. The bandage should be applied as tightly as the patient can wear it with comfort. There is no danger of the circulation by following this rule, as no dangerous constriction of the limb could be endured without pain and discomfort. The bandage thus applied should be worn in general for from four to six weeks, according to the severity of the case, day and night; and, after that, during the day only, or while in the upright position, for from four to eight weeks longer. Many patients prefer to wear them a good deal longer, to prevent any possible return of trouble, but this is in general not at all necessary.

When the bandages are thus applied, great comfort and support are at once experienced, and with these much increased capacity to use the joint. Very soon it becomes evident that absorption of effused fluid, and of the interstitial deposits in the tissues of the synovial sac, and of the other tissues about the joint, is going on; and, in a space of time too short to be credible to those who have not accurately pursued the practice, and carefully and repeatedly observed the fact, the enlarged and weakened articulation is restored to the normal size, and if not immediately to its original strength, to a far greater capacity for use, and eventually to a perfect restoration in all respects.

In cases where the amount of fluid effusion within the sac is small, or where the thickening of the sac is the principal element of the case, these results may be always looked for with certainty and rapidity. Sometimes, however, when the amount of fluid effusion is very large, the use of the bandage *alone* (although of the greatest value as a palliative, by strengthening the joint, and permitting painless use of the limb) will produce *complete* absorption of the fluid very slowly, if at all. The existence of these exceptional obstinate cases induced my father, some twelve years ago, to add to the use of the bandage a preceding thorough aspiration of the sac, all the other points of treatment being exactly as before described. This was done at first only in exceptionally obstinate cases, in which the effusion within the synovial sac was large, but the operation was gradually found to be

entirely free from danger, and latterly aspiration has been practiced in all cases in which, being chronic, the synovial effusion is of any considerable amount, and even in the most acute cases in which rapid effusion produces great distention and consequent pain.

The results of my father's experience are summed up in the following statements:

1. In the last twelve years over two hundred cases of synovitis of the knee, and its sequelæ, have been treated by aspiration with a single strapping of the joint, and subsequent use of the bandage.

2. In these cases the knee-joint has been punctured over four hundred times.

3. In all these cases, with the exception of a very few, and these only in the early stages of treatment, the patient was not only permitted, but obliged to take a daily and considerable amount of walking exercise.

4. In not a single instance has there been failure of absolute and entire cure, requiring, in one case, seventeen weeks, but in no other more than elevan weeks.

5. Although no antiseptic measure, beyond perfect cleanliness of the aspirating needle, was employed, in not one instance has any ill symptom followed the operation. When the needle is withdrawn, the puncture is at once covered securely with adhesive plaster.

Sir Benjamin Brodie long ago declared most emphatically, that when the synovial sac is distended with fluid, it can be punctured, and the effusion drawn off with perfect safety. He does not by any means regard this as a help in treatment, however, as he says the fluid will accumulate again, and in a few hours the joint will be as much distended as before. The originality and value of my father's method of treatment lies in successfully demonstrating the fact that thorough aspiration of the knee-joint, followed by proper use of the rubber bandage, gives us a complete and satisfactory method of cure even in the worst cases of synovitis. By the firm and equable pressure of the rubber bandage, the re-accumulation of fluid is checked. If there is any return of the fluid at all, it is in very much diminished quantity, and a second, or perhaps in severe cases a third, aspiration of the joint is all that is ever required. One great advantage of it is to explode the idea that perfect rest of the joint is the only way to hope for a cure. The patient is emphatically *not* to be confined to bed, or, worse still, to a fixed splint. When the joint is strengthened by a properly applied rubber bandage, exercise is a very great and important adjunct in the treatment. This very day I have visited a lady who passed last summer in Switzerland. While there she was attacked with synovitis of the left knee, with a large amount of effusion into the sac. She was kept in bed, with the limb placed on a fixed splint and continually poulticed. After sweltering through the hot weather with the limb swathed in many thicknesses of cotton wadding, at the expiration of two months the splint was removed, and—she has come home with a joint almost immovable! I am sure that had this case been treated by prompt aspiration of the sac, and the proper use of the rubber bandage, a perfect and rapid cure would have resulted without a week's confinement of the patient to her bed.—*Medical Record.*

AMPUTATIONS AND EXCISIONS.—Speaking of amputations, Mr. Banks, of Liverpool, *Med. Record* (N.Y.) naively remarks that for his part he only knows and only teaches two things about them, viz., to make one flap longer than the other and to saw the bone as low down as possible. I may remark that the size of the flaps is a question on which surgeons differ greatly. Many British surgeons are now in favor of having two flaps of nearly equal size. The "circular" method has also many advocates.

In amputating through the femur for disease of the knee-joint it is difficult, says Mr. Banks, to see any use in keeping the patella. Sawing off its cartilaginous surface and then trying to make it stick on to the cut end of the femur may afford an operator of a mechanical turn of mind some amusement, but nothing more. It is not the patella we want, but the hard skin over it.

In describing a case of double amputation for railway injuries, Mr. Banks alludes to rapidity of operating as an element in prognosis. In this case the patient, a boy of ten years of age, had fallen from a train and lay in a tunnel all night in severe wintry weather. He was apparently dead when brought to the hospital, but some signs of life appeared after a time. Subcutaneous injections of ether were given him (two of thirty minims each) and "he was placed on a mattress opposite a large fire and literally cooked into life again." Reaction had fairly set in by the evening. He was then taken into the theatre, "the smallest whiff of ether" was given him, while the two injured limbs were removed "with all the rapidity possible." Rough dressings of lint soaked in carbolized oil were applied, and the patient "was again in the ward on the mattress before the fire in less than fifteen minutes from the time of his removal." Space fails me to give the full history of this most interesting case, but I may say that the patient was attacked with "surgical scarlet fever," the urine became albuminous, the flaps opened up and refused to heal, and the bones protruded. The patient eventually recovered, a result largely due, Mr. Banks believes, to the speed with which the operations on him were performed. He remarks that in these days of anæsthetics the surgeon is apt to proceed too deliberately, forgetting that the patient, though not suffer-

ing pain is suffering shock—that "every minute of anæsthesia, every fresh incision, every lost teaspoonful of blood," lessens his chance of recovery. Mr. Banks goes so far as to say that in a thigh amputation for smash, the fact of the patient being on the table twenty minutes in one case, or forty-five in another, makes all the difference "between his crossing the bar and sticking on it." In the case just alluded to, the warm fire, subcutaneous injections of ether, the selection of ether as an anæsthetic, and the careful use of antiseptics, all no doubt aided in procuring the favorable result.

Mr. Banks is a warm advocate of ether as an anæsthetic, and even goes so far as to say, "Today it has elbowed chloroform out of the field." This may be so in Liverpool; it certainly is not so in London. Chloroform is still largely used both in hospital and private practice. The A.C.E. mixture is becoming more generally used also. Local anæsthesia is becoming more largely employed. Ether-spray, or ice and salt, is much more often made use of for minor operations than formerly. The introduction of cocaine has stimulated investigators to try and discover some other local anæsthetizing agent. Mr. Banks recognizes two objections to ether. One, the danger of excessive secretion of mucus in bronchitic patients; the other, its failure to thoroughly control muscular action even after feeling is abolished.

Mr. Banks has some very thoughtful remarks to make on the subject of excisions. At the International Medical Congress in London (1881) Mr. Howard Marsh ignored statistics and pointed out that excision belongs to the same class of treatment as amputation. It is giving up the attempt to cure the disease. To this view Mr. Banks cordially assents. Far better than advocating early excision is it, he says, to devote ourselves to teaching the early recognition of hip and joint disease. "The children of rich people," he says, "don't have their hips and knees excised. Why not? Because the articular mischief is promptly found out, and skillfully and patiently treated." Joint diseases are so prevalent in the cold and damp climate of Liverpool, that Mr. Banks' opinion is worth hearing at any rate. I may remark that the Clinical Society's report (1881) on excision of the hip-joint, showed a mortality of thirty-five per cent. in cases of excision as against thirty in cases of suppuration treated by rest and extension.

Mr. Banks says the following is his teaching to students: "In children up to fifteen years of age, if you get a case of knee or hip disease from its commencement, make up your mind to save the limb. You ought to save it. Between fifteen and twenty-five, failure is to be looked for very often, and then you may excise. Don't operate until your art is exhausted—only don't wait until your patient is exhausted. Fortunately after twenty-five or thirty, joint mischief is not common; but at that age whatever you may do with the hip, do not excise the knee, if your patient will let you amputate."

Mr. Banks says that his impression of excision of the knee-joint after thirty years of age is that it is, as a rule, disastrous, and that many a life has been lost to save a leg. On this question many surgeons will be disposed to join issue with Mr. Banks, but one remark that he makes is certainly worth remembering. It is that a workingman does not usually do a stroke of work on an excised knee-joint under eighteen months or two years; after amputation he is at work in from four to six months on a sound stump.

CASE OF CÆSAREAN SECTION PERFORMED BY THE PATIENT HERSELF.—The following remarkable case was related by Dr. von Guggenberg, and the patient exhibited, at the last annual meeting of Bohemian physicians at Tetschen. On September 28, 1876, he was summoned at two in the morning to see a woman, who was said to have cut open her abdomen. He found the patient lying in a miserable house, on a wretched and dirty bed, exhausted and bloodless, and only capable of making affirmative and negative signs. On removing a dirty petticoat which covered her, an incised wound was seen on the right side of the abdomen, passing downward and inward, from which a somewhat large coil of intestine protruded, the greater part of which, covered with dried blood, rested upon a dirty blood-soaked straw sack. Hæmorrhage seemed to have ceased from every part of the wound, and the uterus was contracted to the size of a child's head. A fully developed, but dead, male child lay between the patient's knees. Clean linen was procured from a neighboring house, and, with a piece soaked in oil, the protruded intestines were carefully wiped and returned, and the wound sewed up, the peritoneum being included with the skin. The incision was about three and a half inches long, and slightly S-shaped. It was dressed with a five-per-cent carbolic solution, fixed with strapping, and the abdomen was carefully bandaged. By the afternoon, the patient was able to speak, and next day the history was taken. She had had seven children previously, four of whom had been born without medical assistance, two with forceps, and one after craniotomy. The pains began between September 24th and 25th, ceased in the afternoon, and came on again on September 26th, when the midwife stated that she felt the presenting head on vaginal examination. On September 27th, convulsions came on, according to the patient's account, accompanied by agonizing pain and great distension of the abdomen, the movements of the child ceasing. The pain and distension became so severe that the patient determined to perform Cæsarean section, of which she had heard. She therefore took a razor and divid-

ed the skin slowly; she then made a second and a third incision; and finding the child not yet appearing, made another cut, which caused a large jet of blood to escape, and exposed the placenta; this she removed. One foot of the child came into view, which she seized and pulled upon until the whole of the body came through the wound, the head requiring the exertion of all her force. She divided the umbilical cord, laid the child (which she believed to be dead) beside her on the bed, and threw the placenta on the floor. She had passed neither urine nor feces since September 24th. The progress of the case was very good; urine was passed on the afternoon of September 28th, but the first stool not till October 2d. The pulse reached one hundred and twenty on the day after the operation, but was never again so frequent; the temperature is stated to have been not very high; and, although there was a considerable amount of exudation from the wound, it had united by October 3d. The patient soon returned to work, and has been ever since in perfect health. —*British Medical Journal.*

TREATMENT OF GONORRHŒA.—In the early treatment of gonorrhœa, Prof. Gross condemns the use of injections. His plan is as follows: If possible, put the patient to bed; give him at the outset a purge, by administering Epsom and Rochelle salts, each ʒ ij, in lemon syrup. Allow no meat or any stimulating articles of diet, etc. Malt liquors do more harm than alcoholic, so interdict both. No tea or coffee, but give him milk, eggs and some oysters, etc. Three times daily he is to hold the penis in a cup of hot water—quite hot. Keep the organ there for five minutes at a time, then wipe it gently each time.

The internal treatment will be by the "antimonial and saline mixture":—

℞. Antimonii et potassii tartrat., gr. 1/6
Magnesii sulphatis, ℈ ij
Morphinæ sulphatis, gr. 1/6
Tinct. aconiti radicis, gtt. j
Liquor. potassii citrat., f ʒ ss
Olei limonis, gtt. ss
Elixir. simplicis, f ʒ ss. M.

SIG.—Ter die.

By this treatment the urine will be rendered bland and unirritating. Should the urine persist in "scalding," then add to the above prescription gtt. x tinct. cannabis indicæ. To prevent or cure chordee, order at night a suppository of—

℞. Extract. opii,
Camphoræ, *aa* gr. iij.

In the course of four or five days the discharge from the urethra will look more like laudable pus; then order an injection:—

℞. Hydrargyri chloridi corrosivi, gr. ij
Aquæ destillat., O j.

SIG.—With syringe that holds an ounce, inject into the urethra—having first "flushed" the canal several times by voiding urine—and retain the fluid for five minutes.

Internally, a useful combination is that used at the out-door department at the hospital, and consisting of—

℞. Cubebæ, ʒ ij
Alum. pulv., ʒ j. M.

SIG.—Of this take a heaping teaspoonful in a tumbler of water ter die; the dose to be increased.

Should the discharge per urethram still persist, use an injection of—

℞. Liquor. plumbi subacetatis, f ʒ j
Aquæ, f ʒ x. M.

Or—

℞. Plumbi acetatis, gr. ij
Zinci sulphat., gr. iij
Aquæ, f ʒ j. M.

Or—

℞. Acidi tannici, gr. ij
Aquæ, f ʒ j. M.

—*Coll. and Clin. Record.*

MONSEL'S IRON IN DIARRHŒA.—Dr. E. T. Williams (*Boston Med. and Surg. Journal*), says: "Ever since I began practice in 1868 I have been looking for a really satisfactory astringent in chronic catarrh of the bowels. There is, as everyone knows, a class of cases where the ordinary vegetable astringents fail to act, or at least act too feebly to do real good. The intestinal lining is in an ulcerous, or quasi-ulcerous, condition, and requires the potent action of a mineral astringent to treat it, as in cases of external ulcer The acetate of lead is one of the best remedies in these cases, but cannot be safely given for any great length of time. Oxide of zinc in pill form is safe and efficient, but with children, who must take it in powder, often vomits and gripes. Sulphate of copper and nitrate of silver are still harsher, and for children quite out of the question. Subnitrate of bismuth is worse.

"I began trying, in 1876, at the Seashore Home, iron alum (the officinal sulphate of iron and ammonia). I found it better than anything I had previously tried, and have used it freely ever since. It is not quite so well borne by the stomach as lead and bismuth, but far better than zinc or copper. The dose for a child is from one to three grains; for adults, from three to ten. At the Seashore Home we make powders containing one grain of the salt to a twelfth of a grain of opium, giving one or more for a dose according to the age of the child. For adults the pill form is of course preferable. I have had the best results from its use.

"Last summer I began using Monsel's salt in

its place, both in public and private practice. This I did from my experience of its great efficiency as a styptic, and a presumption that it might do equally well in diarrhœa, and have found it even better than iron alum. I have tried it only in the dry form, manufactured by Squibb under the name of pulvis ferri subsulphatis. In this State it is not officinal, though it is precisely the same as the officinal liquid ferri subsulphatis evaporated to dryness. It may be given in the same doses and in the same way as iron alum."

POPLITEAL ANEURISM SIMULATING SARCOMA.—The diagnosis of popliteal aneurism is not generally a matter of great difficulty, still some of the cases of aneurism simulate other diseases so closely that mistakes are occasionally made. Many able surgeons have opened aneurisms, supposing them to be abscesses, and others again have tied the femoral artery for malignant growths, mistaking them for aneurisms. There are not a few cases recorded where an old consolidated aneurism has been mistaken for a sarcomatous tumor. In the January issue of the American Journal of the Medical Sciences Dr. Francis J. Shepherd, of Montreal, reports an obscure and instructive case of popliteal aneurism, which was under observation for several weeks, and in which there was a total absence of aneurismal symptoms, and the rational symptoms pointed to sarcoma, either of the periosteum or the parts about an old popliteal aneurism, for which the patient had been successfully treated some years before. Amputation was performed, and an examination of the tumor showed it to be solid throughout and composed of fibrin, solidified *en masse*. The orifice of the aneurism was at the distal end of the tumor, and the blood therefore flowed from below up, with, of course, a lessened stream; the circulation, owing to the obliteration of the femoral above the tumor, being carried on by collateral branches. As there was no cavity in the tumor the absence of pulsation and bruit is explained. As there was not a single symptom which pointed to aneurism an accurate diagnosis seems to have been impossible.—*Louisville Med. News.*

THE THERAPEUTIC VALUE OF MILK.—In *L' Union Medicale du Canada*, Dr. H. E. Desrosiers has a very interesting lecture on the above subject. Milk may be used constitutionally and locally. Internally, it is, first of all, a very valuable restorative. It is an article of diet that can be borne when everything else is rejected; and in general the patients like it. It may be used in all diseases characterised by anæmia, debility and asthenia. Among the diseases in which it is most commonly used may be mentioned, idiopathic anæmia, chlorosis, convalesence from debilitating diseases, inflammatory and febrile affections, in cachexias, etc. M. Dujardin-Beaumetz insists upon a milk diet in tuberculosis.

In the above diseases, a milk diet need not always be prescribed to the exclusion of other food. Milk is expressly indicated in the treatment of certain special diseases, such as irritative dyspepsia, gastric catarrh, gastric ulcer, cancer of the stomach, chronic intestinal indigestion, chronic diarrhœa, especially in children; in acute and chronic nephritis, diabetes mellitus, cystitis (especially chronic), gout, aneurism, and organic disease of the heart. In regard to the last, milk is used with most benefit in the period of non-compensation (the *adynamic* period of Peter). Milk has no appreciable effect in affections with compensatory hypertrophy. The intravenous injection of milk has been proposed in profound anæmia, following hemorrhage, etc.; this treatment has met with a certain degree of success in the hands of most observers.

Locally warm milk is a good gargle in acute pharyngitis and tonsiliitis It has also been recommended in diphtheria.

Sometimes skim-milk is preferred by the patients; and it even seems to be better than pure milk in interstitial nephritis. Skim-milk seems easier to digest in gastro-intestinal disorders. It has been employed with success to reduce obesity. Tyson says that it is better than any other article of diet in glycosuria.

Buttermilk, too, has its adherents; and it seems preferable to pure milk in the treatment of the gastro-intestinal disturbances above mentioned.—*N. O. Med. and Surg. Jour.*

NEW OPERATION FOR RUPTURED PERINEUM.—Dr. A. C. Post read a brief paper on this subject before the N. Y. Academy of Medicine. He said that the operation had not been performed a sufficient number of times to entitle it to be regarded as established, but in the three cases in which he had performed it the result had been so satisfactory as to lead him to recommend it to the profession as worthy of trial. The operation was simpler in execution than the one ordinarily performed, and he thought it secured a more solid perineal body, and it also had the advantage that there was no loss of substance in its performance, and consequently it might be easily repeated if for any reason the first operation should fail.

An incision was made each side of the vagina to the depth of fifteen or twenty milimetres. The incisions met in front in a manner to divide the parts into an upper and lower segment. The upper segments were turned up and formed the floor of the vagina, and were secured in position by a row of catgut sutures passed, not through the skin, but through the subcutaneous cellular tissue so as to turn the edges of the skin upward to form a ridge on the floor of the vagina. A second row of sutures, of silver wire, were passed from either side

through the deepest part of the incisions, where the upper and lower segments met. The ends of these sutures were passed through glass beads and perforated shot, and after the flaps were brought into close contact the shot were compressed. The inferior edges were united by fine sutures, and an iodoform dressing was then applied. The integument on the inner side of the thighs should be protected from pressure by the shot and beads. The patient should be allowed to urinate without the use of the catheter, and the parts be washed afterwards with a solution of mercuric bichloride. The sutures might be removed at the end of ten days or a fortnight.—*Med. Times.*

A NEW ABDOMINAL DRAINAGE TUBE.—Dr. H. Marion Sims describes the following new abdominal drainage tube in the *N. Y. Medical Journal*: "It acted so nicely and drained the pelvis so well that he wished to call the attention of the medical profession to it. It consists of a large and a small tube made of hard rubber. The smaller tube is inside of the larger one, running along the posterior wall, and terminating about an eighth of an inch from the bottom. The large

tube is perforated on the sides and curved on the top, so that, when in the abdominal wound, the top of the tube projects nearly over the symphysis pubis. The smaller tube is for the purpose of washing out the peritoneal cavity, the water being thrown in at the bottom of the cavity instead of at the top, as in most draining-tubes. He attaches a small rubber tube at B, and forces the water to the bottom of the tube C with a Davidson's syringe. At the mouth of the tube A he attaches a large rubber tube, and, while washing out, the water runs into a bed-pan or any convenient vessel placed in the bed. Where drainage is constant and very profuse, the rubber tube can be long enough to hang over the side of the bed into some vessel placed there. By having the smaller, or washing-tube project through the dressing on the wound, the pelvic cavity can be washed out without removing the dressing, which will remain dry and clean.

CHLORAL HYDRATE AS AN ANTISEPTIC.—Dr. Warner of Worcester, in a communication to the *Boston Medical and Surgical Journal*, states, that, during the last ten years, he has used a solution of chloral (three to five grains to the ounce) as almost his only dressing, and has found it acts admirably; as, while it is inodorous itself, it removes the fœtor of purulent discharges effectually. It is cheap, and simple in its application, and, causing no stain, can be sprinkled freely about. It seems also to act as a local sedative, often so relieving pain of a recent injury or operation as to render resort to an opiate unnecessary. During the treatment of large suppurating wounds, it keeps the air of a ward or room pure; while there is no danger from its absorption, and the comfort from a light compress moistened in the solution is very great. Somewhat frequent changes are required to prevent the compress from becoming dry and sticky, and secure perfect cleanliness. It acts as a perfect germicide, rendering spraying quite unnecessary. In a solution in warm water, the hands of the operator, instruments, sponges, etc., are cleansed. Dr. Warner speaks of his experience of its employment in various operations producing large surfaces, and greatly prefers it to carbolic acid and other antiseptics. Chloral may also be used with cosmoline or glycerine in the same proportions, if there is any reason to prefer this form of preparation.—*Pop. Science News.*

HOW TO TREAT THE ATTACHMENTS OF UTERINE TUMORS.—Dr. Thomas Keith, *(Brit. Med. Journal)* says: I have no one way in dealing with the attachments of uterine tumors. At present each case must be a law unto itself, and of this part of the operation there is much to be learned. A few of the simpler cases may be treated extra-peritoneally. Generally the broad ligament must be left inside, and sometimes the whole attachment, when there is much enucleation, must be so treated. Sometimes the treatment may be entirely intra-peritoneal by means of Kœberlé's *serre-neud*, or it may be half intra- and half extra-peritoneal. These cases require much care in the after dressing, though the convalescence is much shorter than

when the whole is left outside. I am hopeful that the cautery will yet be the safest and best of all the methods of dealing with some of these tumors. The more I use it in ovariotomy the more I like it. It is simply perfect, and its employment seems to me "a higher exercise of our art" than the ligature, which, apart from the chances of hemorrhage, embraces ten times the amount of tissue that is really necessary. That a more perfect way will soon be found I have little doubt. This will do as much for uterine tumors as Baker Brown's intraperitoneal method has done for ovariotomy ever since 1864.

EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.—Dr. Guttierez reports this curious case in *El Dictamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a fœtal head. Capillary puncture gave a clear fluid containing numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally, the skin, using Lister's dressings. There was not the slightest trace of peritonitis, but reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Journ. Am. Med. Association.*

CORROSIVE SUBLIMATE AND GLYCERINE IN EPITHELIOMA OF THE CERVIX UTERI.—D. Biddle in the *Brit. Med. Journal* says: There are few things in the way of palliative treatment that have given me greater satisfaction than the use, in a case of epithelioma of the cervix uteri, of a lotion, or injection, containing one-fourth of a grain of corrosive sublimate, and half an ounce of glycerine, to a pint of water. Before using it, a patient of mine had, for seven or eight months, been subject to paroxysms of agonising pain, and to frequent hæmorrhages, which were occasionally profuse. Immediately upon its employment, and for the last three months of her life, hæmorrhage became merely nominal; and, instead of agonising pain, there was simply the distress consequent upon irritation (by the tumor) of the bowel and bladder, the latter of which became perforated a week before death. I attribute the beneficial change to the very marked reduction in the amount of infiltration. The lotion was used continuously, with very few exceptions, twice a day during the three months, and I shall certainly adopt the same treatment in the next case I have, even before recovery is despaired of. In the case referred to, it was not tried until the curative effects of chromic acid had been tried in vain.

CARBONATE OF AMMONIA IN SCARLET FEVER.—Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart. of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*The Medical Record.*

TREATMENT OF ZONA.—Dr. Fabre recommends the following treatment of zona: In the beginning of the disease, mild purgatives may be necessary. These should be followed by general sedatives, such as opium, belladonna, and ether, to diminish the pain. Locally, anodyne liniments may be applied and the diseased parts dusted with subnitrate of bismuth or oxide of zinc. If the vesicles are fresh and transparent, they may be aborted by covering them with collodion; but if they have been present four or five days, application of collodion will have no good effect; but, on the contrary, they will suppurate beneath it. The neuralgia which persists after the cure of the eruption should be treated by hypodermic injection of morphine or atropine, and arsenious acid in doses of from $\frac{1}{60}$th to $\frac{1}{30}$th of a grain be administrated internally. —*L'Union Médicale*, Feb. 26, 1885. —*Med. News.*

ANTISEPTIC SILK.—Freeman uses Chinese twist which has rendered aseptic by boiling for ten minutes in a two-per-cent. solution of chromic acid, and then soaking for twelve hours in a one-per-cent. solution of the same. He states that the sutures may be left *in situ* for three weeks without the occurrence of either suppuration or softening of the silk. Silk thus prepared is especially useful in operations about the genital organs in women as well as in laparotomy.—*N. Y. Med. Journal.*

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THE USES OF IODOFORM.

Among German surgeons iodoform is more extensively used than any other antiseptic in the the treatment of wounds. This substance, while less likely to be followed by toxic effects than carbolic acid, is not entirely free from danger. But whilst its careless use may occasion unpleasant symptoms, one very excellent feature in its favor is its freedom from irritating qualities. It may be applied directly to extensive raw surfaces, or dusted into large abscess cavities, without any fear of provoking irritation, and it is only when used in excessive quantities that danger from poisoning may be apprehended. Unlike carbolic acid, it does not increase the amount of serum from a wound.

The utility and general applicability of iodoform is much impaired by the fact that it is insoluble in water. It cannot therefore be used for irrigation, washing, cleansing, disinfecting instruments and the like. It is soluble in ether, collodion and glycerine in the proportion of about one part to ten of either menstruum, and these solutions may be used for dressing wounds. In the treatment of wounds it is generally used, however, in the form of powder, or gauze in which the meshes are thoroughly impregnated with iodoform by dusting and rubbing with the hands. An ointment of varying strength is also frequently used in the treatment of ulcers. Iodoform has been in use for several years past in the Toronto General Hospital in the treatment of chancroid and syphilitic ulcers, chronic ulcers, compound fractures and all unhealthy wounds, and the results have been most satisfactory.

Iodoform is used largely by Billroth and others in the Vienna clinics. Iodoform gauze is the favorite application after operations, especially about the face and throat, in compound fractures and resection of joints. Billroth claims that iodoform possesses anti-tuberculous properties in addition to its antiseptic qualities, and consequently employs it freely in all joint diseases of a scrofulous character. After resecting and removing all diseased bone, the cavity is packed with iodoform gauze. The gauze is used in the same way in the treatment of compound fractures and abscess cavities. Strips of the gauze are packed in alongside the fragments of bone, and in abscess cavities, until the space is completely filled, and over this is placed layers of iodoform gauze and this dressing allowed to remain for several days.

One very effectual method of applying iodoform to an ulcer or wound is by atomization, by means of a spray producer, of an ethereal solution made by dissolving one part of iodoform in from seven to ten parts of ether. Evaporation of the ether takes place in a few minutes, leaving a thin film of iodoform evenly distributed on the surface of the wound. Another very convenient method, when it is desirable to introduce it into a sinus, or abscess cavity, is to inject a solution of one part of iodoform to ten of glycerine, after the cavity has been well washed out. Gynæcologists have for some years past been in the habit of using iodoform as an antiseptic coating for uterine tents, also in cases of endometritis, puerperal septicæmia, and as a palliative and to correct the fœtor of the discharges in cancer of the uterus and rectum. It is not only valuable in removing the fœtor, but also in alleviating the pain and suffering in these distressing affections.

The internal use of iodoform is somewhat limited. Within the past year or two it has been used in the treatment of secondary and tertiary syphilis, when iodide of potassium could not well be borne. We have in our own experience seen some benefit derived from its internal administration in chronic ulcer of the stomach. It has also been used with indifferent success in chronic diseases of the lungs. The dose is from one-half to three grains in the form of a pill.

RESORCINE IN WHOOPING-COUGH.

This remedy has been extensively employed during the last year in the treatment of whooping-cough, with more or less success. Dr. Moncorvo, of Rio de Janeiro, was among the first to bring the treatment into general notice. He strongly advocates the topical employment of resorcine in the strength of one per cent, applied by a fine pencil-brush to the larynx. He gives fourteen instructive cases, of various degrees of severity and duration, in which this remedy was found by him highly serviceable. He gives the following conclusions:

1. That whooping-cough—whose nature, up to a very recent period, has been subjected to the most diverse interpretations, in relation to its genesis—may, to-day, according to the latest microscopic researches, be included in the class of parasitic diseases.

2. That the disease appears attributable to the presence of micrococci which multiply prodigiously in the hyperglottic vicinity of the larynx, infiltrating its epithelial cells, which appear to be the predilective seat of their development.

3. That resorcine, applied to the laryngeal mucous membrane, caused, in all the cases in which it was employed, rapid decrease of the number of paroxysms, moderation of their intensity, and finally recovery in a short period of time, without the aid of any other medication.

Dr. Moncorvo says that resorcine, owing to its less caustic action, and the absence of disagreeable taste and odor, is far preferable to carbolic acid. He has administered it internally to children, even the newly born, suffering under diarrhœa and dysentery. He advises that strict attention be given to the quality, so as to secure the article in purity; and he recommends that prepared by Monnet, of Geneva, which is of notable whiteness, and in the form of silvery bright crystalline needles. It is extremely soluble in water. Dr. M. recommends the topical application with the fine pencil-brush, to be repeated every two hours. The first applications, he says, sometimes exacerbate the coughing fits, but this irritation ceases in two or three days. In twenty cases treated by him, he was not disappointed in his expectation in a single instance; and some of them had been very obstinate, or even dangerously complicated, as with hereditary syphilis, threatened hydrocephalus, pulmonary tuberculosis, intermittent fever, etc.

Resorcine, in its source, being a congener of carbolic acid, no doubt acts in a similar manner as a parasiticide. Dr. Moncorvo states that he has, by numerous microscopic examinations of sputa expectorated by his patients laboring under whooping-cough, verified the statements made by Letzerich, Henke, Steiner, Hagenbush, and other writers, as to the parasitic character or complications of the disease. The treatment advocated by him is, therefore, free from all insinuation of empiricism, and, as the article is not expensive, it will no doubt be largely sought after.

MALPRACTICE SUITS IN FRANCE.

The Paris correspondent of the *British Medical Journal*, for February 7th, gives an account of an interesting suit for malpractice in which an action was brought by an *officier de santé* against M. Trélat, Professor at the Ecole de Médecine, and M. Delens, of the St. Antoine Hospital. M. Bouyer, the plaintiff, stated his case as follows: In the act of nailing down a box in May, 1883, he slightly injured the left forefinger. He sent for M. Piogey, his neighbor. M. Delens and M. Trélat were called in by M. Piogey, and the plaintiff complained that a number of operations were performed on him, and that he was conducted to a *maison de santé*, and that M. Delens applied undiluted alcohol to his bleeding wound; that drainage-tubes were applied, and camphor-dressings bandaged on. After six weeks of daily agony, he left the *maison de santé* with a deformed hand. M. Bouyer accused MM. Delens, Trélat, and Piogey of having treated and tortured him against his will, of having injured him by unskilful treatment, and named his damages at 20,000 francs ($4,000). M. Piogey declared that the plaintiff had a deep wound in the left forefinger, which required constant care day and night; symptoms of septicæmia soon appeared, and it was necessary to call in surgical assistance; very serious lymphangitis had set in, and several collections of pus had formed. The patient expressed gratitude for the care taken of him, and never opposed any part of the treatment, otherwise his wishes would have been considered. M. Trélat accepted the responsibity of having M. Bouyer removed to a *maison de santé;*

his condition required it; he was in an almost hopeless condition, and could not otherwise have had the necessary attention given him. M. Bouyer, the plaintiff, was condemned to pay damages of 3,000 francs ($600), to each of the three defendants. A few such verdicts in Canada would be hailed with delight by the profession, and would most effectually put a stop to much vexatious litigation.

MEDICAL EXAMINATIONS.—The following is a list of the successful candidates in the various Universities and Colleges in Canada, so far as we have received returns.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—FINAL—J. A. Burgess, A. F. Baumann, C. H. Britton, J. D. Courtenay, T. C. Cowan, Margaret A. Corlis, F. W. Cane, H. C. Cunningham, J. A. Couch, F. Campbell, P. E. Doolittle, J. R. Dales, P. A. Dewar, A. W. Dwyer, W. Ewing, D. D. Ellis, D. W. Eberts, J. Ferguson, H. B. Ford, A. Graham, W. J. Gunne, W. S. Harrison, H. J. Hamilton, A. R. Harvie, J. H. Howell, H. H. Hawley, A. R. Hanks. F. Harkin, D. O. R. Jones, J. H. Knight, A. B. Kinsley, C. A. Krick, W. A. Kyle, R. J. Lockhart, W. V. Lynch, A. T. Little, R. Lucy, H. D. Leitch, F. G. Lundy, D. J. Minchin, L. J. Mothersill, J. Marty, W. J. Mitchell, D. C. McLaren, M. C. McGannon, N. McCormack, G. A. Peters, J. J. Paul, W. T. Parry, J. E. Pickard, G. F. Palmer, J. A. Rutherford, H. G. Roberts, Helen E. Reynolds, D. G. Russell, C. F. Snelgrove, J. N. Simmons, A. M. Shaver, S. Scott, J. G. Sutherland, C. E. Stacey, J. A. Stirling, E. A. C. Smith, Wm. Spankie, L. W. Thompson, O. Totten, C. Trow, A. Trudel, J. A. Watson, W. H. Wright, D. J. G. Wishart, E. G. Wood, G. Veitch.

PRIMARY—J. V. Anglin, A. F. Baumann, G. M. Brodie, W. C. Beeman, H. E. Burdett, F. Campbell, Margaret A. Corlis, J. Casselman, J. B. Carruthers, C. R. Charteris, W. F. Cale, G. R. Cruikshank, J. F. Campbell, C. R. Cuthbertson, S. S. Cornell, C. Collins, J. M. Conerty, H. E. Drummond, W. G. Dow, W. Dow, M. L. Dixon, D. Dunton, A. A. Dame, A. Ego, J. H. Eastwood, A. B. Eadie, W. Ewing, J. M. Fraser, E. J. Free, W. H. Fox, Ada A. Funnell, J. M. Forster, D. E. Foley, J. W. Fraser, A. W. Gardner, J. Guinane, W. R. Gillespie, H. P. H. Galloway, T. D. Galligan, W. Giles, W. D. Green, W. J. Glassford, M. J. Glass, D. M. Gordon, J. H. Hoover, W. B. Hopkins, Geo. Hunt, J. W. Hart, C. W. Haentschell, F. C. Heath, J. E. Hanna, A. Hotson, J. A. Harvie, J. H. Hamilton, D. Johnston, M. James, M. J. Keane, D. Kester, W. J. Logie, F. G. Lundy, M. J. Mullock, D. E. Mundell, J. C. Moffatt, C. F. Moore, J. Macoun, W. J. Mitchell, J. C. McCabe, D. C. McLaren, J. C. McAllister, T. McEwen, D. McEdwards, H. A. McCallum, E. McLaughlin, A. F. McVety, J. McLurg, Alice McLaughlin, O. G. Niemeier, W. R. Nichols, T. H. Orton, I. Olmsted, Annie L. Pickering, T. S. Philp, A. B. Riddell, H. G. Roberts, D. Sinclair, E. A. C. Smith, W. Spankie, W. R. Shaw, R. S. Smith, W. O. Stewart, C. R. Staples, J. M. Shaw, H. C. Scadding, D. Storms, J. P. Shaw, J. J. Soden, A. F. Tracey, A. B. Thompson, J. A. Tuck, J. D. Thorburn, A. Trudel, S. West, R. West, W. R. Walters, F. Woodhull, E. J. Watts, R. J. Wilson, E. W. Wright, A. F. Woodward, E. G. Wood, A. E. Yelland.

TRINITY UNIVERSITY, TORONTO.—M.D., C.M.—J. R. Logan (*Gold Medal*), H. H. Hawley (*Silver Medal*). A. M. Shaver, N. Allan, S. Scott, A. Graham, D, C. Throop, C. E. Stacey, W. V. Lynch, H. D. Leitch, C. F. Snelgrove, A. F. Little, F. Campbell, A. Hanks, P. A. Dewar, F. C. Hood, J. Lindsay (*Honors*). R. J. Lockhart, R. Lucy, J. G. Harper, H. G. Roberts, T. S. Farrar, D. O. R. Jones, C. Trow, A. H. Edmison, J. N. Simmons, P. E. Doolittle, W. J. Gunne, H. W. Hoover, O. Totten, J. J. Paul, J. A. Watson, H. S. Bingham, J. A. Couch, J. Ferguson, W. H. Pepler, A. F. Baumann, L. W. Thompson, A. T. Woodward, F. G. Lundy, H. J. Caldwell, J. Evans, G. Leitch, R. A. Barber, J. G. White, S. A. Metherell (M. B.), G. J. Charlesworth, J. E. Jenner, R. M. Fairchild, H. Hislop, and J. D. Wilson.

PRIMARY.—J. R. Logan, H. H. Hawley, John McLurg, James McLurg, J. Hamilton, W. R. Nichols, J. M. Thompson, D. McLauchlin, A. E Yelland, H. Campbell, C. K. Staples, J. E. Midgley, B. Hawke, C. E. Thompson, J. C. Moffatt, D. McEdwards, J. W. Hart, T. S. Philp, T. Primmer, W. F. Graham, W. Panson, M. Maxwell, W. H. Mackay, J. P. Shaw, D. A. Kidd, H. R. McCullough, W. A. Fish, (*Honors*). F. G. Lundy, A. J. Stevenson, W. Giles, H. C. Philips, J. S. Patterson, J. H. Hoover, O. G. Niemeier, F. E. Luke, J. A. Tuck, D. M. Gordon, J. J. Sodon, C. A. Toole, D. Thompson, J. C. C. Grasett, S. H. Irwin, D. Kester, H. Blair, J. W. Shillington, T. Wilson, G. Gordon, S. T. Bell, R. A Barber, J. B. Reid H. S. Bingham, H. J. Caldwell, J. G. White.

MCGILL UNIVERSITY, MONTREAL.—M.D., C.M., E. G. Wood, *Holmes Gold Medal*; S. Gustin, *Prizeman*; F. G. Finlay, H. T. Hurdmann, M. C. McGannon, T. A. Baird, J. Elder, D. W. Eberts, *Honors*. R. H. Arthur, J. H. B. Allan, F. N. Burrows, Geo. O. Cassidy, W. S. Daly, D. Corson, J. H. Darey, H. Dazé, W. W. Doherty, F. McD. Harkin, E. O. Hallet, A. E. Hanna, A. C. Hawkins, R. T. Irvine, H. D. Johnson, W. H. Klock, J. W. McMeekin, N. McCormack, H. J. McDonald, D.

L. McMillan, F. H. Powell, G. F. Palmer, A. Robertson, J. L. Shibley, D. G. Wishart, J. A. K. Wilson.

PRIMARY.—H. A. Lafleur, *Sutherland Gold Medal*; E. J. Evans, *Prizeman*; J. A. A. Kelly, D. L. Ross, E, H. P. Blackader, R. A. Kennedy, L. F. Ross, T. J. Haythorne, R. C. Kirkpatrick, W. Hall, and J. M. Fraser, *Honors*. P. Aylen, C. W Boggs, S. W. Boone, A. W. Campbell, L. H. Carter, W. Cattanach, A. MacD. Cowie, D. McG. DeCow, H. Dazé, J. A. Dickson, E. H. Earl, W. E. Ellis, W. D. Ferguson, E. W. Fillmore, J. D. Flagg, A. W. Gardner, W. C. Haentschell, A. L. Hamer, J. W. Johnson, A. C. Leslie, W. F. Loucks, D. D. McDonald, G. A. McMillan, V. H. Morgan, T. J. Norman, L. E. M. Pomeroy, A. Poole, E. Reavely, G. C. Richardson, D. J. Scully, D. Sinclair, G. C. Stephen, P. H. Warneford, E. P. Williams, J. F. Williams, A. A. Young.

Botany Prize.—T. A. Clouston. *Practical Anatomy.*—1st year, W. J. Bradley; 2nd year, H. A. Lafleur. *Clinical Medicine.*—H. S. Birkett.

TRINITY MEDICAL COLLEGE, TORONTO—*Fellowship Degree.*—H. H. Hawley, *Gold Medal*; J R. Logan, *1st Silver Medal*, A. M. Shaver, *2nd Silver Medal.*—D. C. Throop, C. F. Snellgrove, S. Scott, A. T. Little, *Honors*. N. Allan, A. Baumann, H. S. Bingman, J. A. Couch, F. Campbell, H. J. Caldwell, P. E. Doolittle, P. A. Dewar, A. H. Edmison, T. S. Farrar, A. Graham, H. W. Hoover, E. C. Hood, A. R. Hanks, D. O. R. Jones, R. Lucy, H. D. Leitch, W. V. Lynch, J. Lindsay, R. J. Lockhart, J. J. Paul, W. H. Pepler, H. G. Roberts, C. E. Stacey, J. N. Simmons, O. Totten, J. Watson.

Primary.—H. H. Hawley, J. Hamilton, J. R. Logan, Jas. McLurg, W. R. Nichols, J. M. Thompson, *Honors*. H. Blair, S. T. Bell, R. H. Barber, H. S. Bingham, T. F. Campbell, H. J. Caldwell, W. A. Fish, W. Giles, W. F. Graham, D. M. Gordon, G. Gordon, J. C. C. Grasett, B. Hawke, J. H. Hoover, J. W. Hart, D. Kester, D. C. Kidd, F. G. Lundy, D. McLaughlin, J. E. Midgely, J. C. Moffatt, D. McEdward, M. MacDowell, H. R. McCullough, O. G. Niemeier, G. S. Paterson, H. C. Phillips, T. S. Philp, T. Primmer, J. B. Reid, J. W. Shillington, C. R. Staples. A. J. Stevenson, J. P. Shaw, J. J. Soden, J. A. Tuck, C. E. Thompson, C. A. Toole, D. S. Thompson, T. Wilson, A. E. Yelland.

Scholarships.—First, 1st year's scholarship, G. H. Fere; second, 1st year's scholarship, W. S. Cummings; second year scholarship, John McLurg; third year scholarship, W. H. McKague. Upwards of 80 candidates successfully passed the first year's examination.

QUEEN'S UNIVERSITY, KINGSTON—*M. D.*—W. Spankie, B. A., and H. C. Cunningham, equal. *Gold and Silver Medals.*—T. A. Bertram, C. W. D. Clarke, Mrs. Corlis, H. G. Dawson, A. W. Dwyer, H. B. Ford, E. Hooper, W. A. Kyle, Helen E Reynolds, H. Ray, D. G. Russell, J. A. Stirling.

Intermediate Examination.—T. A. Beeman, H. Burdett, Joseph Casselman, C. Collins, N. Coy, A. A. Dame, Miss A. E. Dickson, M. L. Dixon, F. D. Gilligan, G. C. Jack, A. Jamieson, W. M. Mather, P. J. Mellow, E. J. McArdle, E. McLaughlin, A. F. McVity, Miss M. Oliver, T. B. Smith, D. Storms, E. W. Wright. *Primary and Intermediate.* — F. Bruce, J. M. Conerty, S. Cornell, J. G. Creeggan, B.A.; E. J. Donovan, D. E. Foley, F. C. Heath, B.A.; J. J. Lane, D. E. Mundell, J. Mundell, J. M. Shaw. *Hospital Surgeons.*—M. L. Dixon and D. E. Mundell. *Demonstrators of Anatomy.*—E. W. Wright and J. V. Anglin.

VICTORIA UNIVERSITY—*M.D.C.M.*—J. Barber, A. W. Bigelow, J. A. Burgess, J. R. Dales, J. S. Freebourne, W. A. Goodall, S. M. Hay, A. R. Harvie, L. L. Hooper, H. J. Hamilton, C. J. C. O. Hastings, A. B. Knisley, E. E. King, J. Marty, W. C. McKinnon, H. McGillivray, J. E. Pickard, W. T. Parry, D. Pool, P. P. Park, J. A. Rutherford, J. G. Sutherland, L G Smith, W. T. Teasdall, T. Verner, D. M. Williams, H. A. Wright, H.A.Wright, W. H. Wright, G Simenton.

Primary.—G. M. Brodie, D. B. Cruikshank, J. Caven, F. Campbell, E. Campbell, J. A. Carbert, C. R. Charteris, A. E. Collins, C. R. Cuthbertson, W. G. Dow, W. Dow, D. Dunton, W. H. Fox, E. J. Free, W. G. Glasford, P. H. Galloway, W. R. Gillespie, A. O. Hastings, W. B. Hopkins, R. Hillier, G. Hunt, S. J. Jones, J. Leeming, J. M. McCallum, C. F. Moore, T. M. McFaul, C. F. Nairn, J. F. Orr, J. Rea, P. J. Rice, W. R. Shaw, J. C. Smith, W. B. Thistle, A. F. Tracey, J. C. Vrooman, R. J. Wilson, S. West.

ONTARIO MEDICAL ASSOCIATION.—We desire to draw special attention to the meeting of the Ontario Association, which will be held in London, Ont., on the 3rd and 4th of June. A number of interesting and valuable papers have been promised and every effort is being made by our brethren in London to make the meeting a success, and from what we know of the Western men, we feel assured that nothing will be left undone that can contribute in any way to make the meeting in every respect a success. It will be remembered that this year a new departure will be inaugurated. Instead of the annual reports on medicine, surgery, and obstetrics, the chairmen of the committees respectively will open the discussion on specified subjects, as follows: Medicine,—Dr. Tye, of

Chatham, Diphtheria; Surgery,—Dr. Powell, of Edgar, Plaster Splints; Obstetrics,—Dr. Temple, of Toronto, Intra-Uterine Medication. The usual certificates will be issued by the Secretary entitling members to reduced rates by the different railroad lines. We trust that there will be a full attendance of members.

ONTARIO MEDICAL COUNCIL ELECTIONS.—The elections for representatives to the Ontario Medical Council takes place on the 26th inst. Candidates for the Territorial Divisions must receive the nomination of, at least, *ten* registered practitioners resident in such Division, and forward the same to the Returning Officer for the Division on the 5th of May. Voting papers will be issued by the Registrar on the 12th inst. Among the candidates recently brought forward may be mentioned Dr. Jas. Russell, of Binbrook, for the "Burlington and Home" Division, Dr. McDonald, of Hamilton, having retired. Dr. Russell has received a numerously signed requisition, and his election may be safely counted upon. Dr. Orr, of Maple, has also received a large requisition to become a candidate for the King's and Queen's Division, and intends to contest the seat with the old member, Dr. Allison.

ANÆSTHESIA BY THE MIXED METHOD. — This method of producing anæsthesia has been highly spoken of by many leading surgeons. It consists in the administration of a hypodermic injection of morphine and atropine prior to the inhalation of ether or chloroform. The stage of excitement is very slight, anæsthesia occurs more rapidly and the patient rarely vomits. A large dose of bromide of potassium on the evening and morning before the operation, has been found to bring about similar results, and is worthy of further trial. In a few cases in which we have tried it, the good effect has been very wonderful.

APPOINTMENTS *Re* NORTH-WEST REBELLION.—Dr. Bergin, (M P.,) has been appointed Surgeon-General, and Dr. Roddick, of Montreal, Deputy Surgeon-General; Hon. Dr. Sullivan, Purveyor-General; Dr. Orton, M.P., Brigade Surgeon.

HOSPITAL AND AMBULANCE CORPS.—C. M. Douglas, Surgeon-General; Dr. Bell, of Montreal; Dr. A. Graveley, of Cornwall, Ont.; Dr. J. Reddick, of Winchester, Ont.; Dr. E. Hooper, of Kingston, Ont.; Dr. F. H. Powell, of Ottawa, Ont.; Surgeons. FIELD HOSPITAL, No. 2.—D. H. Casgrain, of Windsor, Ont.; Surgeon-Major, Dr. R. Tracey, of Belleville, Ont.; Dr. N. O. Walker, of Toronto, Ont.; Dr. Francis Murray, of Montreal, Que.; Dr. Cloutier, of St. Arsene, Que.; Dr. Phillippe Pelletier, of Quebec; Surgeons. Dr. Nattress, Surgeon-in-Chief of the Red Cross Corps. Along with these, a staff of medical men, medical students and dressers have gone to the front.

Dr. E. Allen has been appointed Surgeon to the 30th Wellington Battalion of Rifles, and Dr. W. H. Johnson, Assistant Surgeon.

MERCURY AND IRON.—We have seen it stated that iron given with mercury would prevent salivation from the latter. We have tried it many times, giving it in small doses for a long time, without salivating our patients. How much this result depends on the iron given with the mercury we cannot say, but it is a fair presumption that the iron has some effect in preventing the bad effects often accompanying fractional doses of mercury long continued, especially when it is necessary to continue its use for the cure of syphilis.

The *London Medical Times* considers the following the most unfortunate *lapsus calami* which has come under its observation for a long time. The hero of the young lady novelist has succeeded with great difficulty in saving the heroine from falling down the precipitous side of a mountain on which they have lost their way. The heroine has fainted and is apparently lifeless. But to his intense delight the gentleman discovers that the heart still beats "by the pulse in her femoral artery."

DOBELL'S SOLUTION.—The following, which is a very pleasant, soothing, cleansing, and disinfectant wash, is especially recommended in the local treatment of catarrh, laryngitis, &c.:—

℞	Acid carbol.		ʒss.
	Sod. bicarb,		
	Sod. bibor,	aa.	ʒj.
	Glycerini,		℥j.
	Aquam,	ad.	Oj. M.

SIG.—Apply with a nasal syringe or by insufflation.

COMPOUND FERRIC MIXTURE.—The following which is an excellent tonic and hæmatic, is said to

be used in the Charing Cross Hospital, London, Eng. :—

℞	Ferri sulph.		grs. xx.
	Potas carb.		grs. xxiv.
	Sachar, alb.		grs. xlviij.
	Aq. cinnam.		℥iv.
	Aq. puræ.	ad.	℥viii.

SIG.—One to two tablespoonfuls three times a day.

THE DYSPNŒA OF BRIGHT'S DISEASE.—In a paper read before the Canada Medical Association by Dr. Howard, of Montreal (*Can. Med. & Surg. Jour.*), on the varieties of dyspnœa met with in Bright's disease, he illustrated the following points: (1) That marked dyspnœa may occur in Bright's disease not due to gross lesions in the lungs, pleura, or heart, such as inflammation or œdema of the lungs, hydrothorax, or pleurisy with effusion, endoor peri-carditis, or valvular disease. (2) That it may be continuous dyspnœa, or of a paroxysmal character, resembling ordinary spasmodic asthma; and that these types may occur in the same case, although in his experience, the continued variety is more frequent than the asthmatic. (3) That these forms of dyspnœa may occur as the prominent symptoms of renal disease, and their origin may escape recognition if the urine be not carefully examined, as well as the heart and pulse. (4) That Cheyne-Stokes respiration is often a symptom of Bright's disease, and that it obtains in both acute parenchymatous and in chronic interstitial nephritis. (5) That while usually an evidence that the fatal issue is near at hand, it may occur in a chronic form, and may occur for weeks, perhaps even for years. (6) That these several forms of dyspnœa just mentioned are very probably due to that defective renal elimination called uræmia. (7) That in the acute forms of Bright's disease, serious or fatal dyspnœa sometimes, but rarely, occurs in connection with effusion into the submucous membrane of the larynx (œdema glottidis).

LOCAL APPLICATION FOR PILES.

℞	Pul. opii.		
	" Aloes	aa	grs. v.
	Ext. Hamamelis,		℥j.
	Cosmoline,		℥j. M.

SIG.—Sponge the parts with warm water and apply after each defecation.

PARALDEHYDE IN DELIRIUM TREMENS.—This new remedy has been found successful in the treatment of delirium tremens, after the failure of potassium bromide, valerian, hyoscyamus and morphine to produce sleep. This agent is claimed to be a hypnotic, producing a perfectly natural sleep of from two to six hours' duration, from which the patient awakens without any sense of distress, headache, dulness or nausea. It may be administered in the form of an elixir, two drachms of the drug being dissolved in an ounce of simple elixir and a tablespoonful administered, to be repeated when necessary.

BRITISH DIPLOMAS.—Drs. Davidson and Furrer, (Trinity), have been admitted to the M.R.C.S., Eng. Dr. W. A. Goodall (Toronto) has obtained the License of the King's and Queen's College of Physicians, Dublin.

We are very much pained to learn of the death of Private Ferguson, son of Dr. R. B. Ferguson, of Winnipeg, in the Fish Creek battle. The Dr. has our deepest sympathies in his severe family affliction.

CORONER.—Dr. J. M. Cotton has been appointed coroner for the County of York, Ont., and Dr. G. Schmidt for the County of Waterloo.

The death of Dr. Jas. L. Little, of New York, is recorded in our American exchanges.

Notes, Queries and Replies.

To the Editor of the "CANADA LANCET."

SIR.—If your correspondent, who asks for experience regarding the use of picrotoxine as a remedy for sweating in phthisis, will refer to McKesson & Robbins "Formula Book," he will find some remarks which influenced me in selecting this drug. I have employed it in cases of sweating from various causes and am very much pleased with the result. Yours truly,

J. H. BURNS, M. D.

Toronto, March 31st, 1885.

To the Editor of the CANADA LANCET.

SIR,—The following question was given at the late Council examination: What poison can a woman take to poison her child, without injuring herself, through her milk, and how can you detect

it by *post mortem* examination of child after death? Will some one please answer in next LANCET?

Yours respectfully,

L. J. MOTHERSILL.

Tuscarora, April 28, 1885.

Books and Pamphlets.

INSANITY AND ALLIED NEUROSES; PRACTICAL AND CLINICAL, by George H. Savage, M.D., M.R, C.P. Physician and Superintendent of Bethlehem Royal Hospital, &c. Published by Henry Lea's Son & Co., Philadelphia.

The American reproducers of this work have probably long ago learned the fact that a large book is, in the eye of the student of any branch of medicine, a large evil. They have therefore contrived to squeeze into this unpretending little octavo, on fine paper and in clear type, a quantity of most instructive solid matter, which might not inexcusably have been made to fill one of twice the size. Never has it been our good fortune to rise from the perusal of any work on insanity with more thorough gratification than we have realized throughout all its pages. It was our intention to present to the readers of the LANCET some extracts from which they might be enabled to form an anticipative opinion of the real merits of the book; and with this view we made notings of such passages as appeared to us most saliently instructive, but before we had got over half the pages, these markings had become so numerous that we have reluctantly felt constrained to relinquish our purpose.

The book is presented as a "Manual for Practitioners and Students." Every practitioner of medicine is, or ought to be, a student of insanity; therefore it would not have at all derogated from the dignity of the former to have passed them over unnamed. It is sincerely to be hoped that those of ripe knowledge and prolonged observance will not allow themselves to be distanced in the field of alienism by their juniors. A little money devoted to the purchase, and a very little daily time to the study of Dr. Savage's plain and modest treatise, will not fail to prove profitable investments. But whatever may be the appreciation in which it may be held by the general profession, it is sure to be highly valued by the entire body of alienistic and neuropathic specialists. Every man who has had any lengthened experience in psychiatry, and has loved his work, will feel, in reading Dr. Savage's graphic and succient description of cases, as if he had been erewhile walking arm in arm with the author, for years, through the wards of his own asylum; and the retired veteran will have displayed before him a living panorama of mental scenes and shadings, which must revive his remembrance of many anxious and many pleasant days in his past life,—scenes and shadings which lapse of years may have begun to enshroud in the gloom of clouded remembrance, but whose reproduction he will contemplate with a kindred gratification to that of the tired pilgrim on his return to his youthful home.

We cannot but commend Dr. Savage's book to every member of the medical profession, and to every student who aspires to the possession of a sound practical knowledge of mental disorders. It is quite probable that if more attention were given to this department of medical science, the public would be relieved from witnessing many of those scenes of professional conflict in courts of law, which are the opprobria of our profession.

THE POPULAR SCIENCE MONTHLY FOR MAY, 1885. New York: D. Appleton & Co. Fifty cents a number, $5 a year.

The first paper, "Our Recent Debts to Vivisection," by William W. Keen, M. D., is a graphic account of the benefits that have been conferred upon humanity during the last quarter of a century, by means of experiments on animals. There is no strained construction in the argument, and the numerous examples given cannot easily be explained away. Dr. Max von Pettenkofer's valuable and timely papers on "Cholera" end in this number, with the fourth of the series, which is mainly devoted to the subject of prevention. "A Scientific View of the Coal Question," by G. Gore; and "Training in Ethical Science," by Mr. H. H. Curtis, are able articles. "The Nervous System and Consciousness," by Professor W. R. Benedict, illustrated, and "Arctic Exploration and its Object," by Dr. Franz Boas, are both good papers in their respective departments. There is also an article by Professor Tyndall, describing the patient labor, the ingenious methods, and the grand results of "Pasteur's Researches in Germ-Life."

THE EAR, Its Anatomy, Physiology and Diseases, a Practical Treatise for the use of Medical Students and Practitioners. By Chas. H. Burnett, A.M., M.D., Professor of Otology in the Philadelphia Polyclinic and College for Graduates in Medicine, etc. With 100 illustrations. Second edition, revised and rewritten. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The above work will be cordially received by the profession, especially those members who have become acquainted with the author through a perusal of the first edition, or in attendance upon his lectures on this subject. His style is clear and concise, and his methods attractive. The work of revision has been carefully done, and much new matter, rendered necessary by the progress of the science, has been added. The author in the outset gives a description of the anatomy of the parts, which is followed up by a description of the instruments used, and how to handle them, and concludes with a clinical history of the various diseases and their appropriate treatment. The work will be found very useful to those desirous of acquiring a knowledge of the diseases of the ear.

THE SCIENCE AND ART OF SURGERY. By John Eric Erichsen, F. R. S., LL., D., F. R. C. S., Emeritus Professor of Surgery in University College, etc. Eighth Edition Revised and Edited by M. Beck, M. B., Lond., F. R. C. S., Eng. Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Vol. II. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

We have already noticed with comments the first volume of this classic work on surgery, and it only remains at present to notice the issue of the second volume. It embraces a consideration of those affections, not included in the first volume, and contains an appendix on corrosive sublimate as an antiseptic. We cannot speak too highly of this excellent work. It represents the most advanced and settled views in regard to the science of surgery, and will ever be found a faithful guide and consellor in practice.

KIRKE'S HAND-BOOK OF PHYSIOLOGY. By W. Morrant Baker, F. R. C. S. Lecturer on Physiology at St. Bartholomew's Hospital; and Vincent D. Harris, M. D., London, Demonstrator of Physiology at St. Bartholomew's Hospital. Eleventh edition with nearly 500 illustrations. Vols. I. and II. New York: Wm. Wood & Co.

The above work constitutes the February and March Nos., of Wood's Library of Standard Medical Authors, and will no doubt be hailed with satisfaction by the subscribers to this "Library." Kirke's Physiology is so well known to the profession that an extended notice would be quite superfluous; the fact that it has reached the eleventh volume speaks for itself. All the recent advances in the science have been incorporated in the work so as to bring it fully abreast of the times.

AN INTRODUCTION TO PATHOLOGY AND MORBID ANATOMY. By T. Henry Greene, M.D., Lond., F. R. C. P., Lecturer on Pathology at Charing Cross Medical School. Fifth American and sixth revised and enlarged English edition, with one hundred and fifty engravings. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

This able and instructive work is well known to the profession, and the edition before us fairly represents the status of this important branch of medical study. It is a lamentable fact that too little attention is paid to pathology and its sister science physiology by the majority of medical practitioners on this side of the Atlantic. A careful perusal of such a work as this, however, cannot fail to arouse an interest in the study of this much-neglected branch of medical science.

BERLIN AS A MEDICAL CENTRE, by H. R. Bigelow, M D., Washington, D.C.

The above work will be issued by the New England Publishing Co., Sandy Hook, Conn., during the month of May. It will be a complete and accurate medical guide to Berlin, giving instructions in reference to board, clinics, lectures, expenses, etc., and all information that will be necessary for the medical student abroad. The price will be $2.

Births, Marriages and Deaths.

On the 15th ult., J. T. Small, M.D., M.R.C.S. Eng., of Toronto, aged 63 years.

On the 29th March, D. A. Livingstone, M.D., of St. Chrysostome, Que., aged 30 years.

On the 10th ult., J. McCurdy, M.D., of Chatham, N.B., aged 42 years.

On the 11th ult., D. Burnet, M.D., of Cobourg, aged 40 years.

On the 23rd March Dr. Thomas Tanner, M.D., of Holstein Ont., aged 64 years.

THE CANADA LANCET.

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Original Communications.

ON THE BROMIDES IN EPILEPSY.

BY PROF. G. LEE, HOTEL DIEU (*Revista Argentina*).

Translated from the Spanish by J. Workman, M.D., Toronto.

What part of the therapeutic action belongs to the potassium, and what to the bromine? The action of the bromide of potassium on the organism has passed through strange vicissitudes. In the outset all the effects were ascribed to the potassa; after the labors of Traube the effects of the potassic salts became known, particularly of the nitrate on the heart, which, after a short period of excitement, suffered a certain degree of depression, with diminished blood pressure; and it was hence concluded that all the salts of potass, whatever might be the acid or the metalloid, possess true therapeutic properties; but experience soon showed the complete inertia of the chloride, the nitrate and the iodide of potassium in the treatment of epilepsy; it was then proved that potass in general, in whatever dose or combination, did not possess the least therapeutic influence over epilepsy.

This was the second phase of the bromide, diametrically opposite to the first. It is necessary to divide and separate the physiological action into two parts; on the one side, to discover its effects on the brain, the medulla and the skin, which represents its special nature; and, on the other side, its effects on the circulation, the respiration and the temperature, which would be those of its common or alkaline nature.

Here now we have the potass pretty well demonetised; but the physiologist limits himself to a few hours of observation on some animal whose intelligence he cannot penetrate, whilst the clinicist sees and follows the cerebro-spinal phenomena for a long time, and does not hesitate to recognize the pre-eminence of clinical medicine; it is this which teaches the therapeutic properties, and above all the cerebral action, of the bromides in general, and of the bromide of potassium in particular.

The latest investigations by Kroy, on man, show clearly that all the virtue resides in the bromine; yet, on the contrary, on animals, the excessive proportion of 67 per cent. of bromine against 33 of potass in the bromide passes, or may pass, through without producing the least effect.

The third vicissitude undergone by the bromide of potassium, not only despoiled it of its curative property, but transformed its action on the heart into a real intoxication of the organ; in this turn the disadvantages of bromism were imputed to the potass, which was regarded as decidedly lethal; and it was believed that it was merely necessary to replace it by some other alkaline base, in order to get clear of all the dangers of a drug which is prescribed through months and years. This gave birth to the bromide of sodium, the bromide of ammonium, and lastly to the mixture of these two with the inevitable bromide of potassium. The polybromides, perhaps for the very reason that their complex effects are unknown, are to-day much employed, as a consequence of the potassophobia; yet it is enough to know that the habitual dose of six grams of the bromide of potassium introduces into the system only two grams of potass. How has it happened that such a dose, taken into the stomach, has never produced the the least inconvenience?

The ashes of alimentive vegetables represent 3 to 4 % of their entire mass; the mineral residues of the potato contain 60 % of potass, that is to say, more than a grain and a half for every 100 grams of the tuber, and yet neither its sedative virtue, nor the danger of its use, has ever been suspected. Lastly, it is easy to prove that in order to obtain the equivalent effects of 5 grams of the bromide of potassium, the dose of the bromide of sodium must be raised to 10 or 15 grams. So, in order to avoid a very uncertain danger, we inevitably, by this excessive dose of the bromine, fall into the grave inconveniences of bromism, as is proved by the convulsions caused by injections of the bromide of sodium, just as by those of the bromide of potassium, into the blood of animals. Rochefonte has demonstrated this by his investigations in my laboratory. The bromide of am-

monium is still more exciting, so that the three united salts do not present any advantage over the potassic bromide, which figures for one-third in the mixture styled the polybromide.

Absorption and Dose—Effects of the Bromide on the Eliminant Organs—Slight Bromism of the Respiratory Mucous Membrane, and of the Skin.

The bromide is readily and promptly absorbed by all the mucous membranes; after some minutes it appears in the urine, and is eliminated almost in totality in two or three days; hence the imperious necessity of continuing the treatment without interruption; at the most it may be suspended for a day at a certain time, or the dose may be decreased; but to suppress it is dangerous. I have seen patients who, from having neglected the use of the medicine for a few days, have been attacked with convulsive fits after a quietude of eight months or a year.

The bromide is eliminated by the kidneys in great part, very little by the salivary glands, and still less by the stomach; and these organs are, as we shall show, but little impressed by it. The same fact does not apply to the respiratory mucous linings, which also serve as a means of passage to the bromide; they are profoundly altered in its elimination. The pharyngeal mucous membrane becomes the seat of a pricking, painful sensation, and of a well-pronounced paleness, due to the local ischæmia; after the doses have been raised to five or six grams, the velum palati is anæsthetised more or less completely. Voisin, who has closely studied the effects of the bromide, advises that it be taken to the extent of 10 or 12 grams, that is to the production of insensibility of the isthmus of the fauces, which would be the sign of saturation; but there are such individual differences in this respect that we should run the risk of poisoning the patient before this indication of brominal impregnation might appear, which is, so to say, *en passant*, perfectly useless. Voillez has spoken of directly anæsthetising the fauces with gargles strongly bromidised, with the view of restraining the cough as well as the vomitings that follow the kinks in whooping-cough and phthisis; this mode of extinguishing the impressions of sensibility, which provoke the reflex acts of coughing, has had no good result; it is, in fact, very difficult to prolong the contact of the bromide with the pharyngeal wall until we effect the loss of sensibility of the mucous membrane. The bromide does not act until after the gastric absorption, and the commencement of elimination of the bromide by the mucous membranes. For the same reasons we do not obtain, unless with difficulty, insensibility of the mucous membrane of the larynx from the mere action of bromidal sprays; in order to extinguish the sensibility of the larynx, as well as of the pharynx, it is necessary to imitate the process of Voisin, and saturate the patient; but to push to this extremity is very dangerous.

The bronchii are frequently the seat of a sharp irritation, which results precisely from the elimination of the bromide by the secretory glands, when it is presented as well as in the bronchial mucosa, in saturated epileptus; this bromic bronchitis, which is introduced by a short, irresistible cough, dry at first, and followed by a slight expectoration, is one of the most grave obstacles to the continuous treatment which epilepsy demands; I had believed it well to quiet this cough, which occurs chiefly in the night, by conjoining atropia with the morphia, but the result of the combination was generally harmful: either the cough did not cease, and it became necessary to interrupt the treatment, and even in three of the most grave cases to give up all medication; or, though the narcotics succeeded in calming the cough, yet they nullified the effects of the bromide; it appeared to me, however, that the tincture of the root of aconite, in doses of one grain per day, presented some advantages over the other narcotics, and above all over the expectorants (such as antimony, sulphur, turpentine), which only aggravate the evil. What, then, after these facts, which are so easily proved, are we to think of the prescription, in obedience to certain precepts, of the bromide in bronchial irritations?

I do not know of any sort of cough, whether of whooping-cough, of hysteria, or still less of tuberculosis, in which relief is derived from the bromide; the very contrary is the result. It must be stated that these prejudicial effects are observed even with the moderate doses of three grams; I have seen a young epileptic girl who could never exceed the dose of a gram and a half. What, then, would have been the result of large doses? In studying the grave bromism we shall find pulmonary inflammations resulting from the abuse of

bromine; I could cite three unfortunate and convincing examples.

In the skin, as in the bronchii, both a slight and a grave bromism are produced. It is very rare that the bromide, which is eliminated by the integument during life, or, in fatal cases, is found in the sudoriferous glands and likewise in the sebaceous follicles, does not, from the first day, produce a very evident effect on both layers of the skin; even from the first day, in small doses, it produces acnes, which are seated preferentially on the face or the breasts; two or three grams suffice to bring this eruption, and it may be generalised and become numerous, so as to prevent the continuation of the treatment. In these cases I have always employed, with good results, arsenic in addition to the bromide; of late it has been proposed to use the bromide of arsenic, but it offers no advantage over the bromide of potass., with the addition of 10 or 12 drops daily of the solution of Fowler.

The kidneys are not changed either in structure or function in the elimination of the bromide; they do not secrete a larger quantity of urine than they do in the normal state, consequently the bromide cannot be regarded as a diuretic. Neither does the bromide change the composition of the urine; we merely know that it contains more chloride of potass, which leads to the supposition that the bromine leaves its base and that it joins with the sodium in the blood, forming the bromide of this substance; this would be another proof that it is the bromine alone which acts, whatever may be the alkaline base; we shall see presently whether it acts on the oxidations, and consequently on the quantity of uric acid and urea eliminated in the urine.

The salivary glands eliminate the bromide with less facility than they do the iodide, but if the dose be increased a notable quantity is found mixed in the saliva; at the same time there is manifested, without doubt from the reflex action produced by the bromine on the maxillary nerves, a salivation which is frequently abundant and dangerous, and contributes not a little to the enfeeblement of the patients.

The gastro-intestinal mucous lining seems to be but little impressed by the bromide; it causes gastric pains at the moment of its introduction into the stomach, but these may be avoided or calmed by diluting the salt with a sufficient quantity of water; the majority of patients, especially if they take the medicine in solution in their aliments, experience no change in the gastro-intestinal functions, nor any painful sensation, dyspepsia or constipation. This functional immunity leads us to suppose that the medicine is not eliminated by the digestive mucous linings, as iodine is. The secretory organs most briskly attacked are, as is seen, the respiratory mucous membrane, on the one part, and the integument on the other. This is what constitutes the first degree of bromism, as indicated by Huchard.

The Bromide is a Vaso-Constrictor-Medicament, that is to say, an Anemiant.

After having shown the bromine as acting solely by reason of its two constituent elements, and having pointed out the first degree of bromism of the skin and the bronchii, we now come to define the true and useful properties of the bromide. The principal are two; one proceeds from the vaso-constrictor effects, that is to say, from its anemiant action; the other consists in its depressing action over the general reflex power, and more still over the excitability of the general cortex (*? cerebral*).

The faculty possessed by certain energetic medicines, of acting on the vessels through the intervention of the vaso-motor-centre, has long been established; some provoke contractions of the vascular muscles; such are the bromide of potassium and the ergot of rye; others cause active dilatation of the arterioles, as we showed, conjointly with Meuriot, 20 years ago; others paralyze the vascular tunics, as the nitrates of amyl and soda; with the last named we may include curare. It is very remarkable that these medicaments are precisely those which have been prized in the treatments of epilepsy, and often for curious reasons; for example, the bromide to combat the genital excitation; belladonna to diminish the spasms; curare to provoke a curative fever, and the nitrates as energetic and rapid sedatives. In reality, if we abandon the false data of empiricism, and seek for the scientific solution of this complex problem, therapeusis and experimentation fall into accord, and we easily comprehend how so important a role is acted by these vascular-medicaments, and why they deserve to be taken into consideration, despite their qualities, most diametrically opposite from the point of view of their vaso-motor action.

The bromide is undoubtedly an anemiant; Sakokoski, Samola, Sezutzki and all the experimentors are unanimous on this point. By exciting, in the vaso-motor centre the constrictor nerves, the field of the circulation becomes restricted, particularly that of the bulb and the encephalon; it is known that anemia of the medulla oblongata is an experimental character of epilepsy. How are we to reconcile with this fact the beneficial action of the bromide? The reply is easy. The epileptic fit begins with anemia, resulting from the excitation of the vaso-constrictor nerves; against this transitory phase the bromide is powerless, but the fit continues and it ends in a hyperæmic process which provokes vaso-dilatation. It is by its antagonistic and vaso-constrictor action that the efficacy of the bromide is explained; but this is not all: it possesses, as we shall show, a strongly depressive power, or as we might say, a destructive one, over the reflex excitability, alike over the brain cortex and the bulb; consequently it impedes the attack and may also restrain the evolution of the disease

Well now, is there a single vascular medicament that can be compared to it? Not one. The ergot of rye, which is a vaso-constrictor, visibly excites the reflex power of the medulla; belladonna, which is a vaso-dilator, excites the reflex excitability; as to curare it meets no requirement whatever, by paralyzing the vessels it operates lethally; as to the nitrites of amyl and soda, they have but an ephemeral effect on the fit and the vertigo, and they are, so to say, impracticable because of their toxic action. It now remains for us only to prove the depressing property of the bromide on the excito-motor system.

The Bromide Represses the Exaggerated Excito-motility in Epilepsy.

Hurette and Rames, in 1850, recognized in the bromide the anti-excito-motor property which readily explains the insensibility of the pharyngo-laryngeal mucous lining, under the influence of large doses. Laborde has studied this special faculty, which acts also on the genital innervations. Since my first investigations in 1858, when my attention as well as that of Brown-Sequard, was given to the hypnotic, or better to say the sedative effects, which in no respect resemble narcotism, and consist above all in a diminution of the impressionability by external influences, the bromide, taken to the extent of three or four grams nightly, has procured the most tranquil sleep, leaving no vestige of heaviness or pain in the head, such as follow the action of opium. I have utilised this sedative potency of the bromides from the outset of the megrim, which aborts, or is in a certain way shortened.

All these clinical facts ought to leave not the the least doubt; an experimentation of late by Albestoni, lauds a physiological proof that seems to me irrefutable, and applies marvellously to epilepsies of cortical origin. By electrising the cerebral cortex, after laying it bear with the trephine, Albestoni produced partial, and often general convulsions; when he previously administered to the animal under experiment two or three grams of the bromide, the electro-excitability of the cortex diminished considerably, and so much the more the longer the action of the bromide was kept up. The medicine, in a certain dose, impedes the electricity in producing convulsions; it appears that resistances are formed in the bromidised encephalon, or this propagation of the excitation to the psycho-motor-centres is prevented. There is then produced a true excito-motor-paralysis, which is all the more curious as the voluntary movements continue unaffected. In proportion to the suppression of the bromide, this state of the encephalon disappears; it recovers its prior excitability, and the electric excitations acquire their convulsive potency.

It is impossible, in this ingenious experiment, to ignore the proof of the depressing power of the bromide over the excitability of the brain. In comparison, Albertoni met with nothing analagous in belladonna or atropia, nor in curare; all these poisons increased or exaggerated the reflex sensibility; nothing further then is to be expected. The bromide is the unique vascular medicine, and at the same time a real anti-excito-motor.

Grave Bromism.

It now remains for us to point out the inconveniences, frequently the dangers, of an intense and continued bromidation.

When it is prescribed without the precautions we have indicated, permanently in six grams or more, the patient is exposed to grave alterations in the skin, the mucous membranes—principally the respiratory—failure in the heart's action and

the circulation, and general depression of the encephalic system. I thus summarize the grave bromism: The mouth acquires a foul odor, the gums become pale, and an incorrigible salivation is established, which rapidly saps the powers of the patient. The heart acts slowly and weakly; in doses of 15 grams daily its beats are reduced to half the normal number; by prolonging the administration of these doses, the intra-cardiac nerves and the cardial muscle itself, may suffer a commencement of paralyzation. At the same time the intravascular pressure is weakened, and the temperature may descend. What is still more grave is the deterioration, or general impairment, produced by a well-marked elimination of phosphoric acid and urea. The peripheral circulation feels this loss of the general forces and of that of the heart; the patient acquires an extreme paleness, with brownish tints, or the extremities even assume a livid hue, which indicates sanguineous extases. The respiration is, in its turn, attacked; besides the cough and the bromidic bronchitis, which are frequent and often severe, I have seen a mortal pneumonia, which I attributed to the bromide, three times produced; one of these cases was followed up by my colleague and friend Peter; it was that of a girl, with deformity of the cranium, who was attacked by epilepsy; the second case was also of a girl who was an idiot; she died of pneumonia with grave alterations of the skin; the third patient was a boy of four years, who took five grams of the bromide prescribed by a physician who treated him by correspondence.

It is, finally, necessary to signalize that excessive debility which amounts even to impossibility to walk, and to hold the trunk erect, a sort of drunkenness, with general insensibility, somnolence, expression of horror, depression of memory, involuntary emission of urine. As soon as any of these manifestations are presented, all treatment should be suspended for a longer or shorter time, and the doses that have provoked the bromism in the skin, the respiratory or the nervous system, must not be renewed.

Physiological Rules of Bromidation.

It is not enough that we prescribe the bromide even in regular moderate doses, sufficient to obtain a favorable, and above all a definitive, result; it is important to observe all the rules taught by physiology, for the diminution of reflex excitability. I described these in 1868; they may be found clearly formulated in those valuable annotations which my friend and co-worker, Labadie-Lagrave, has added to the book of Hammond, of which they constitute the complement, and are at the same time an indispensable commentary. I quote textually thus: "The efficacy of the bromide depends almost exclusively on the depressing action which it exhibits over the reflex power of the medulla oblongata and spinalis. Everything that may counterbalance this action, everything that may awaken the morbid excitability of the nervous centres, must be severely proscribed. Epileptics must be forbidden alcoholic drinks, wine, beer, or gaseous waters; alcohol and carbolic acid singularly arouse the faculties of the excito-motor and bulbo-medullary systems. Coffee and tea usually have the same result. The patients must abstain from smoking; the nicotine, by exaggerating (?) the vascular action of the bromide, and in a certain way tetanising the arterioles of the nervous centres, seems to extinguish the useful effects of the bromide. Violent gymnastics, the various hydropathic practices, particularly sea baths and douches, have a very fatal action, by provoking return of the fits. The same result follows physical pains, moral emotions, and genesic excitations."

I forbid all active medication, such as purgatives, emetics, revulsives, cauteries, etc., which are capable of producing a great disturbance of the organism; with still greater reason is it necessary strongly to prohibit abstractions of blood.

Auxiliary Means.

The auxiliary means which I have been enabled to approve of, are iron, especially the tartrate of potass and iron, one gram daily; arsenic under the form of Fowler's solution, 12 drops daily; quinia in extract and the sulphate of quinine; lastly, cod liver oil, and above all oxygenation by permanent residence in the country; such are the strengthening medicaments destined to combat the dangers of bromism and the weakening of the nervous system.

Bodily exercise in the open air, without fatigue, moderate intellectual work, well directed, constitute the most important auxiliaries—let these be attended to above all in controlling the education

of children; the due functioning of the brain hinders it from atrophying. It is to be kept in mind that functional debilitation of the brain leads to exaltation of the medullo-bulbar system, and therefore tends to exaggeration of the excito-motor power, that is to say, to the return of the epileptic fits.

The bromide, in medium doses of five to six grams, rather exalts than depresses the intellectual powers, which are generally intact between the fits, often indeed much developed, as I have seen in numerous examples; history records great geniuses of this class, as Cæsar, Mahomet and Petrarch, who were epileptics.

General Results of Bromidation in the Various Epilepsies, and their Principal Manifestations.

1st. Of 150 epileptics treated by me in 25 years, 90 of whom have been closely observed, during two years and over, the majority began the treatment in ages between 10 years and 30; the commencement of the disease dated back to various epochs; among those who had not reached ten, or who had passed 30, I cite the following: a boy of two years, who had never been able to take more than 25 centigrams of bromide per day, without falling into a profound prostration; he remained without treatment during four years; afterwards he took the bromide, and the fits disappeared. In an analogous case, in a boy of three years, the dose of a gram daily continued for two years, brought about, after some periods of physical depression, a complete cure, and he has continued free for many years. Amongst those over 30 years old, I mention one patient of 52 years, whose mother was an epileptic; his attacks had lasted over 20 years; he marvellously recovered, and his children are exempt from the disease.

2nd. Among these 150 epileptics, I count 10 cases due to deformity of the cranium with idiocy; not one of these was cured; three died after some alternations of relief; death in two of the three was due to bromidic pneumonia, and in the third to ulcerations of the skin, with cachexia. In the remaining 140 cases, I have noted three of vertigo without fits; in one of these the disease has resisted all treatment; it was that of a well-formed girl, very intelligent, who had 40 vertigoes daily; all the means employed were useless; the bad result of the bromide is explicable by the circumstance that it is much less operative in cortical than in vaso-motor epilepsy. (?)

3rd. All the rest of the patients had convulsive seizures, some of which were preceded by asthma *(asma, ? aura)*. In the great majority, whatever had been the previous number of the attacks, the disease was ameliorated in this way: the crises disappeared, not to return, unless rarely and far apart, and always so attenuated that the patients did not fall, nor lose consciousness, or have convulsions. Two-thirds of the patients in this category were followed and observed for years; 12 recovered completely, and were able to leave off all treatment. All those who did not recover had suffered the effects of bromism up to the point of being forced to give up the treatment, for a certain time at least; three young girls and a boy of four years had bromic disturbances of the bronchii, so persistent that I was obliged to renounce the bromide, or arrest its affects with aconite. In five other instances I had to contend with bromism of the skin, which became the seat of general eruptions that were often confluent; here the addition of arsenic almost always succeeded in removing this complication. When these difficulties were surmounted, I had nothing to fear, unless errors of hygiene, regimen and drink; unseasonable or too long bathing, and above all hydrotherapy, which hardly ever failed to produce disastrous effects.

4th. The effects of the treatment on the brain have been almost always favorable. Bennett, who has published a series of statistics in this relation, proves the perfect maintenance of the general and the intellectual powers in at least three-fourths of the cases submitted to bromidation, throughout five years. When the intellect becomes weak, the fact is always attributed to the treatment; it is easier and less humiliating to the relatives to fall upon this alternative than to admit the real cause, which is the disease, invading and degrading the brain as it progresses.

In fine, the majority of the organs remain intact; their functioning continues normal, and bromidation, well directed, with observance of the precautions indicated, may produce a definitive cure.

Luton of Rheims, and Verneuil of Paris recommend strychnia in hepatic affections of alcoholic origin.—*L'Union Medicale.*

REPORT ON SURGERY*

BY W. BURT, M.D., PARIS, ONT.

NERVE-STRETCHING.

The following summary, gleaned from the "Bradshawe" lecture, delivered by John Marshall in December last, gives us the principal information now in our possession in reference to this recent operation. In the operation of nerve-stretching there is a palpable stretching. Nerves nearer to the spinal cord are rather more extensible than those at a distance. This may be owing to the relatively less thickness of the sheath. The distant nerves are smaller, but they are probably better protected. The nerves of the upper limb are more extensible than those of the lower limb, probably for the same reason that the nerves of the lower limb are better protected by sheaths; for we must recognize that it is the sheath that bears the strain when we pull upon a nerve. After a nerve is stretched it recoils. One observer states that after stretching a nerve it recoiled one-fortieth of its length. The safe therapeutic weight varies from about 1 lb. up to 30 lbs. The former, for the smaller nerves, as the mental, the latter for the great sciatic. When nerves are stretched, the epi- and perineurium lose their wavy appearances and become straightened; the natural segmentation of the medullary sheath gives way to an irregular breaking up. Sometimes the tubuli break, and still more rarely the axis cylinder gives way. After this the nerve degenerates, and after the whole mass of nerve has become disintegrated, restorative changes follow and its function is gradually restored. Sensation and motion are the first to be extinguished, and lastly reflex action.

Effects on the Cord.—Practically there is no stretching mechanical effect propagated through the roots of the nerves to the spinal cord. In the sciatic, the stretching effect passes to the sciatic plexus, passes to the roots of the nerves, where it must disturb the spinal ganglia on the posterior roots and it must disturb the dura mater. It may by disturbing the dura mater shake the cord a little through the ligamentum denticulatum on either side, but we find no change of tension in the intra-spinal or intra-meningeal part of the nerve, and no movement in the cord. The effects are bilateral. The effect of stretching nerves on one side passes over in various degrees to the other side of the nervous system.

Therapeutics.—Specially successful in peripheral paralysis and neuralgias of all kinds; less so in tetanus; still less so in epilepsy and tabes. In the case of neuralgias, the presence of nervi nervorum is assumed, and that it is through the rupture of these that the pain is got rid of. Nerve-stretching is said to act, not only by rupturing the assumed nervi nervorum, but in other cases by partially benumbing or paralyzing the internal tubules, arresting their function for a time, or, further, by indirect effects on nerve centres. In tabes and central neuralgias it is said to act by producing some indirect effect upon central nerve elements through trophic changes, probably induced by the disturbance of vasi-motor action.

The operation is performed, with one exception, by exposing the nerve, lifting it with the thumb and finger until a *palpable* stretching is produced. Sufficient force is to be used until the nerve sensibly yields to your traction—until you feel an internal creeping movement in the particles of the nerve, of the sheath, no doubt; until you feel a certain attrition and vibration going on—and you must educate yourself to that, and then you will be safe. The thumb and finger can stretch with a force equal to a weight of 30 lbs., the amount said to to be sufficient for the largest diseased nerve, the sciatic. Stretch both ways for neuralgia. It is of less consequence to stretch from the extremities in tabes; it is essential to stretch from the trunk or body. A continued even force, firm and resolute, is desirable. Without cutting, Sayre reports, a positive improvement in tabes in thirteen out of fifteen cases, from the use of his suspensory apparatus, for ten minutes three times a week, the sciatic can be well stretched by forced flexion of the lower limb. It appears from the above that the cutting operation should not be resorted to for tabes. The dangers are those of chloroform, thrombus, pyæmia, and disease of the spinal cord, set up by the operation.

NEUROTOMY.

To the above collection of material in reference to nerve-stretching, I might add the result of neurotomy in a recent fatal case of traumatic tetanus. Patient had the last phalanx of the left

*Read before the Ontario Medical Association.

ring-finger crushed, splitting the bone into lateral halves. As much of the phalanx was removed as was thought would insure ready healing. When the finger was about healed he complained of not feeling well, but kept at work. On the second day of illness, found jaws closed and spasms coming on, causing him to rest on his abdomen and chest. On the third day. temp. 102; neurotomy of the ulnar, median and radial nerves was performed, completely isolating the finger. The joint was removed at the same time. Chloral and potass bromide were used. By evening the mouth could be opened with the greatest freedom, and only during the spasms would it shut violently. The spasms, however, continued; the temperature gradually rose, and on the third day after the operation death ensued. The only direct effect of the operation, in this case, was the relaxation of the muscles of the jaw. The reason of the delay in operating in this case, was the almost total absence of the spasms for a time, under the use of the chloral and bromide mixture. They however returned violently, although the medicine was kept up with the result above stated. There appears no doubt that it is through the medium of the nervous system that the blood changes if any are induced. I have no doubt, however, that the pathological changes take place first in the nervous system, whether the disease be idiopathic or traumatic.

ACCIDENTS OF GAMES.

Foot ball.—I will simply quote a few paragraphs that should prevent a Canadian adopting the rude and barbarous sport of the United Empire. I refer to the Rugby game. What is said by surgeons in England against foot ball, is aimed chiefly at the Rugby rules. If these rules are entirely done away with, or even modified, I believe it will be because of their unaminous condemnation by the profession. Surely unavoidable accidents happen only too frequently without playing according to rules, the inherent nature of which will lead to serious injuries. A. Williamson, manager of the Northern Accident Insurance Co., states in the *Lancet*, "that he had been compelled to decline renewing all special policies covering foot ball and bicycling accidents only, as our experience went to show that these risks, as a special class, were most unprofitable." The accidents attending other sports cannot be numerous or dangerous, for he states, "all our general accident policies cover these risks (foot ball and bicycling) without extra premium." The *Lancet* states that our often repeated assertion that accidents arising from foot ball, as at present played, are more numerous than those occasioned by any other athletic exercise. One of the most painful features of foot ball is the fact that so many of the injuries received in playing this game, when not immediately fatal, often incapacitate the player for life, and render him a burden on his relatives. Such phrases as the following appear in the English medical periodicals, referring to the Rugby game: "The uncontrollable brutalities and roughness of the pastime."—"Brutal and dangerous." Without doubt the consensus of opinion of surgeons is that no such game as the Rugby should ever be indulged in. Under modified rules accidents happen only too frequently. During two seasons of short duration your reporter observed in the matches he played in, a broken clavicle, a dislocated elbow, a fractured pelvis, a case of temporary unconsciousness, besides many minor injuries, chiefly bruises to the shins and ankles. Even this much happened under rules which did not permit the carrying of the ball. From the medical literature on the subject, it appears that those who would approve of the Rugby game, and who see in it manly qualities, would approve likewise of a bull or cock fight. The chief danger of the Rugby game appears to be affections of the spine, resulting in muscular paralysis.

Cricket.—This pastime is not altogether free from accidents, but I think it may be asserted that if the crease is a good one the accidents will be few. The players who receive most bruises are the wicket-keeper and the batsman. If played, however, according to custom and rules, bruises are very rare. In the past two years while on the cricket field, I noticed a fracture of the zygomatic arch, in a wicket-keeper, and a fracture of the nasal bones in a batsman. Both of these accidents were due, it is altogether likely, to an imperfect crease. No game it appears could be more free from accidents, although it is not uncommon to see a wicket-keeper or a batsman lay sprawling on the ground from the ball occasionally striking the testicle, but the injured one soon recovers and proceeds with the game. Accidents of a more serious nature are very seldom reported from the cricket field.

Lacrosse.—Accidents in this game occur undoubtedly, in proportion to the manliness of the

players, whether they play with the ball or play at each other. It will rest mainly with the umpire if accidents are numerous. It is in their power to prevent them. Many a scalp wound and bruise has occurred unnecessarily; but neither in lacrosse nor in cricket is there any special injury which has taken the name of the sport.

Lawn Tennis.—It is to lawn tennis that we look for special accidents that have taken the name of the game.

1st. We have lawn tennis arm, a rupture of the pronator radii teres, produced by the back stroke.

2nd. Lawn tennis leg, a rupture of the plantaris, the symptoms of which are quite marked and uniform.

3rd. Lawn tennis knee. This last consists in nearly every conceivable sprain or bruise of the ligaments and cartilages of the knee-joint.

I shall not refer to the various motions which produce these injuries, but will simply state that it is well to know that these injuries are inherent in the game of lawn tennis, which has now become so fashionable. An intelligent knowledge of these minor accidents, as it were, are not beneath the careful study of the surgeon. And here I cannot help referring you to an exceedingly clear report of a case of lawn tennis leg, by Dr. Powell, of Ottawa, in the London *Lancet*, of July 7th, 1883.

Bicycle.—As to the bicycle accidents, although their name is legion, there is none which have the name of the game. It is simply alleged that varicose veins of the lower limbs, as well as varicocele, may be caused by it, and that hernia inguinal, if not produced, is at least aggravated by it, but the evidence is as yet conflicting.

Base-Ball. — Accidents from this sport are divided chiefly between the pitcher and catcher. A few years ago I observed, in a pitcher, a swelling and tenderness in the region of the attachment of the biceps to the head of the fibula, no doubt due to a sprain of the muscle. The pitcher's movements are such that it is altogether likely this injury may result from it. On advising him to abstain altogether, he got well, but before doing so the trouble was aggravated at every attempt. He can now, however, ride the bicycle without any return of the affection whatever.

The above is simply an imperfect glance at the accidents in connection with the out-door sports which are so much indulged in.

GUNSHOT WOUNDS.

And here I wish to quote from a lecture delivered by Sir Wm. MacCormac, of St. Thomas' Hospital, London. He states: "That there is infinitely more danger created by the surgeon who attempts to search for and extract a bullet, than would result from leaving half a dozen bullets to take care of themselves." This has not been my own experience in reference to pistol-shot wounds. I shall refer to only one example. A patient came under my observation, who accidently shot himself in the wrist. He was kept under ether some three hours, it was alleged, but the bullet was not discovered. Considerable inflammation in and about the wrist, with stiffening and a contracted hand following, which only yielded after prolonged treatment. This may have happened without the prolonged search, but with my present knowledge of the subject if the bullet required a search in order to find out its locality, the search should not be made." Further on he states in regard to gunshot wounds of the abdomen: "Some months ago Marion Sims published, in one of the medical journals, an interesting series of papers in which he said that these injuries should not be left to themselves; but what he proposed was that the abdominal cavity should be opened and searched, the bullet be found and extracted, the peritoneal cavity then be cleansed antiseptically and closed, after which treatment it might be possible for recovery to follow, when death was otherwise almost inevitable." Such it appears has been the action taken in reference to gunshot wounds, which has been attended with the best results. But the change is not general yet, and it is to draw attention to this important subject that the above short report of gunshot wounds is made.

MEDICAL NOTES FROM THE NORTH WEST FIELD FORCE.

BY G. STERLING RYERSON, M.D.C.M., L.R.C.S., ED.
Acting Surgeon, Royal Grenadiers.

It speaks well for the constitutional stamina of the regiment to which I belong and also for the field force generally, to be able to report that there is no serious illness among either officers or men. Diarrhœa has been somewhat prevalent, owing largely to the akaline character of the water, which only was obtainable. There have been a few cases

of dysentery also. Coughs and colds have been common, as might be expected in men unaccustomed to live in tents. Only one case of pneumonia has occurred in this column and that in a man who had suffered from it before. Rheumatism is also met with, but almost invariably of the muscular variety; four men who had suffered previously from chronic articular rheumatism were sent to the rear from the Grenadiers. The sufferings from cold and exposure on the north shore of Lake Superior were most intense, but the men bore up with a most cheerful uncomplaining spirit and no serious trouble arose from it. The most trying part of the journey was the night march on the honey-combed ice, of ten miles to Red Rock, in a blinding rain storm. The men were so exhausted that some went to sleep standing up.

The supply of food has been ample and of good quality, but there has been a great dearth of vegetables, canned or otherwise. Lime juice ought to have been sent to supply their place if unattainable. Common salt is also scarce. Oatmeal would be a boon to the troops. Milk can be occasionally had at 50 cts. per quart and butter at $1 a pound. The scouts bring in captured cattle which keeps us supplied with fresh meat. The difficulty in obtaining fresh supplies can be imagined when I mention that we are 230 miles from the nearest railway station and in an enemy's country, where the people are forbidden by the rebels to sell us anything on pain of death. We are obliged therefore to help ourselves whenever the opportunity presents itself.

The medical officers with this column are Dr. Orton, P. M. O., Drs. Codd, Grant, Whiteford and myself. I have also eight trained ambulance men under me, with Hospital Sergt. Hazelton belonging to the Grenadiers. They have proved of great use in the recent troubles, and I should urge on all medical officers the formation of such a corps in their regiments; one or two men per company, with one regulation stretcher to every four men is sufficient. The wounded in the battle of Fish Creek were promptly removed to the rear by the bandsmen of the 90th Battalion. They showed great devotion and courage, and were often under fire, as were also the surgeons in going to the front to arrest hemmorrhage. I would particularly mention Drs. Whiteford and Grant.

The case of Lieut. Morrow, who was accidentally shot by Mr. Fox, *Mail* correspondent, at Camp Desolation, is interesting. The ball entered the thigh at its anterior and inner aspect, ran under the skin for about six inches, there the probe stopped. As I could feel no ball I cut down on the end of the probe and found that the probe then took a direction downwards and backwards towards the buttock. I passed the probe in its full length, seven inches, and as I could feel no ball I determined to leave it, especially as he had to travel 60 miles in an open sleigh to get to Dog Lake Hospital. The first direction of the ball was towards the middle of Poupart's ligament, and it is most curious and providential that it should have taken a turn at an obtuse angle and passed into the back of the thigh. A somewhat similar case is that of Pte. Swan, 90th Batt., who was shot at the battle of Fish Creek, April 24th, in the inner side of the left arm at its middle third just over the brachial artery. The ball passed beneath the skin under the edge of the deltoid and disappeared in the axilla. No irritation had occurred a week after the wound had been received. The wounds in this action were nearly all given by large round balls from smooth-bore shot guns. They caused great bruising and crushing of the tissues. Their course was often circuitous. Pte. Kemp, 90th Battalion, was struck just to the outer side of the femoral artery as it enters the thigh. The missile passed between the muscles of the abdomen, followed around the loin and lodged in the muscles of the back. There was cellulitis but no peritonitis. A curious case was that of Lieut. Swinford, who was shot the same day. The ball struck him at the temporo-frontal suture, about two inches above the zygomatic process The skull was extensively fractured, and there was hernia cerebri, but he was conscious and rational. In this state he continued with occasional nocturnal delirium for five days when his speech became impaired, and he died on the sixth day with symptoms of pressure. At the *post mortem* the ball, a large round one, was found imbedded in the brain at a depth of about two inches. Some portions of bone were found driven in. The skull was extensively fractured on the injured side.

A son of our esteemed confrére Dr. Canniff, was wounded in the same action by a round ball. The projectile entered the posterior surface of the right forearm about three inches from the olecranon process on the radial side and lodged an inch above it. As the arm was in extension at the time it was

wounded, and as no opening could be found into the joint, it is believed that it escaped.

Three amputations were performed, two through the middle of the arm and one at the surgical neck of the humerus, also one excision of the elbow joint shattered by a shot, but vessels intact. All were doing well when they left for the base hospital at Saskatoon, on May 1st. The total casualties were 31 wounded and 10 killed, including 1 officer killed and 3 wounded. The wounded were transported to the rear in stretchers made of hides slung in waggons. They were all comfortable on starting.

Camp, Fish Creek, N. W. T., May 2nd, 1885.

Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

May 5th, 1885.

Dr. Stark, Vice-President, in the chair.

Dr. Mullin exhibited a pathological specimen—an ovum of two months.

Dr. Leslie then read a paper on "The Germ Theory." The paper went very extensively into the subject from a theoretical point of view, dealing with the researches of different observers as to the nature of cells, and from these proceeding to a description of the various kinds of germs. The subject of spontaneous generation was then taken up and the questiom of disease germs was considered. After a lengthy description of Lister's views and system, and the various opinions with regard to it, reference was made to Koch's investigations as to the nature of cholera and the discussions that had arisen. Drs. Mullin and Malloch both supported the germ theory, the latter especially speaking with reference to Listerism, which he considered to be increasing in favour and had exerted a beneficial influence. Dr. Rosebrugh gave the particulars of an interview had in Edinburgh with Keith as to the sufferings of the latter when using the carbolic acid spray, and the necessity arising for its discontinuance. Dr. Rosebrugh also spoke of his observations in London and Birmingham, all of which tended to show how much operations now depend on cleanliness. Dr. Leslie, in responding, stated that though at present he thought the evidence was against the germ theory, yet the growth and multiplication of germs in the body was a strong argument in its favour.

May 12th.

The President, Dr. White, in the chair.

Dr. Malloch presented a pathological specimen—carcinoma of the pyloric end of the stomach. Dr. McCargow showed a finger which had been opened for whitlow, but too late, as there was denudation of the cartilage of the articular ends of the first phalanx and the adjoining metacarpal bone of the left fore-finger, while there had been a large abscess formed under the pectoral muscles of the same side extending from the axilla, its original site, to within an inch or two of the sternum, and extending downwards over a space corresponding to three or four ribs.

Dr. Rosebrugh then read a short paper on "Intra-uterine Medication." The paper began by referring to the fact that in the greater number of cases of apparent disease of the inner surface of the organ there is, as a rule, some special cause for the symptoms, such as a flexion or version, which removed, the symptoms will soon disappear under very mild treatment. Consequently in all uterine diseases great pains should be taken to make a correct diagnosis, for experience shows that when the case is thoroughly understood the treatment is simplified and more easily accomplished. As an instance, was given the alarming symptoms presented by a case of chronic retroflexion with laceration of the cervix, so easily relieved if these primary conditions are only remedied. The class of cases requiring intra-uterine medication were summarized as follows: 1st, chronic endometritis with the following characteristics: general enlargement of the body of the organ; considerable dilatation of the corporeal cavity, and the endometrium in a condition of fungoid or cystic degeneration, giving rise to a muco-purulent leucorrhœa and frequently to a profuse menorrhagia. 2nd, uterine catarrh, with an albuminous secretion that persists, despite ordinary treatment. 3rd, habitual abortion, independent of syphilis and ovaritis, and seemingly due to some morbid condition of the endometrium. 4th, membranous dysmenorrhœa. 5th, the flabby uterus frequently associated with subinvolution. Having spoken of the difficulty of separating the treatment of the endometrium from that of the os and cervix, while often if the disease of the latter is removed there is no further trouble with the former, the essayist stated that he no longer used tents to dilate the cervical canal, as he found that the applicator

or curette could be introduced without any previous dilatation. If any was needed, the steel dilator could easily effect it. He stated that he had never used strong caustics in the solid form, though where the endometrium is decidedly diseased it becomes more tolerant of heroic treatment; but in such cases he found the most effective agent to be the fuming nitric acid. This he applies by means of the cotton-wrapped applicator, guarded by a glass tube through the cervix, the lining membrane being pretty well swabbed. Except in obstinate cases, and then only at long intervals, the application has not to be repeated. Never had he seen colic or the other alarming symptoms frequently generated by crayons of strong, solid caustics. Churchill's tincture of iodine has been proven one of the most efficient applications, its action being that of a local stimulant to uterine contraction and a general alterative or nutritive. Nitrate of silver he seldom employs, because of its severity as an astringent to the small blood vessels, and its continued use causing too much contraction of the os and cervix. Its use should be confined to the soft flabby uterus with enlarged patulous os and profuse cervical discharge, its contracting effects being carefully watched. Carbolic acid and glycerine, one part to three, is a favorite mild application, the acid coagulating the albuminous secretion while the glycerine depletes the congested condition of the parts by causing a profuse watery discharge. Persulphate of iron is also a favorite with him when wishing to produce an astringent effect upon a granulating surface. Tannic acid is also a useful mild astringent, but has, like iron, the disadvantage of discoloring the patient's underclothing. Paquelin's cautery and the actual cautery he had no personal experience of, having always effected his purpose by other methods. Intra-uterine injections he considered of service sometimes, but on account of the pain and violent symptoms sometimes following; thought milder methods should be adopted. In old chronic cases, with the uterus decidedly enlarged and diseased, and the os flabby and patulous, the organ is so tolerant of manipulation that even injections may be employed with comparative safety. Whenever fluids are to be injected the cervical canal must be straightened and enlarged so as to admit Chamber's reflex current catheter, or some such device, which will secure a free return of the fluid. A safe method is the use of a small graduated hard rubber uterine syringe having a long slender nozzle. The syringe having been filled with the fluid to be used, the nozzle is loosely wrapped with absorbent cotton and introduced within the cavity, and then injecting carefully and slowly just sufficient to saturate the cotton, the syringe is slowly rotated so as to swab the whole inner surface. But as injections offer no marked advantage the essayist thinks they should be abandoned, or certainly very rarely employed. In some cases caustics and astringents effect only partial cure. In obstinate endometritis with fungoid degeneration a muco-purulent discharge and long continued menorrhagia, energetic measures are necessary. The denudation of the endometrium must be penetrating. The most effectual method is by thorough curetting. The uterus should be firmly held by tenaculum or vulsellum forceps and the rough portions scraped out without any previous dilatation of the cervical canal. During the curetting, one hand should be placed over the uterus externally, pressing it down so that every part of the inner surface can be reached. The cervix becomes more tractable so that subsequently a larger curette may be employed if necessary. After the denudation the inner surface is to be thoroughly swabbed with fuming nitric acid, Churchill's tincture of iodine, Monsel's solution of iron, or some other agent of a penetrating character. Local treatment must be supplemented by constitutional. Aim at reducing the enlarged uterus by ergot and strychnine, followed by tonics, quinine and iron. In old chronic cases the curetting may have to be repeated two or three times after the menstrual periods, for, do what we will, relapses will occur, so that the treatment must be persevered in. In treating these disorders the constitutional element must be considered, for in some cases both local and constitutional causes are met with, and in most cases constitutional treatment is of great service, but we must aim to remove the cause, whether local or constitutional. Dr. Rosebrugh said that the frequency of the application depended upon the agent employed—as a rule every fourth or fifth day; if the patient came from a distance, once a week. He nearly always employs the cotton-wrapped applicator, and in order to thoroughly cauterize the surface makes two or three applications at each visit. In many cases where the endometrium seems involved he restricts the application at first to the

cervix, and this with constitutional treatmcnt proves sufficient to induce uterine contractions, and the improvement is continuous until a complete cure is effected. When the inner surface is roomy, and the os very patulous, admitting applicator readily, he pushes the applicator into the cavity and swabs the inner surface and then swabs dry with absorbent cotton the cervical portions of the uterus and vagina. A tampon of absorbent cotton, moistened with glycerine and having a withdrawing string attached, is left in the vagina a few hours. In the discussion which followed, the members differed on the following points:

Dr. Malloch thought more attention should be paid to malpositions of the uterus, and that when these were remedied only mild topical applications were necessary, such as hot water.

Dr. Mullin thought the uterus should be regarded as amenable to medical influences as other internal organs to which topical treatment could not be applied. Local treatment might be useful in certain conditions, but in his experience the conditions which give rise to menorrhagia were not always to be benefited by local treatment, on account of the pain suffered from intra-uterine applications, and after these applications had been abandoned he had found some patients much benefited and restored to health by rest, especially during and after the menstrual period, and the use of general remedies.

Dr. Stark said that while he agreed with Dr. Rosebrugh in his treatment, he preferred to treat the patients at their own houses so as to have the benefit of rest at once. He expressed himself as being at first astonished at Dr. Rosebrugh's heroic use of the curette. Since then he had had great success with it.

Dr. Ryall referred to the fact that formerly the great object in treatment seemed to be the dilatation of the cervical canal, while now gynæcologists sought by means of trachelorraphy to close up the canal, and in conclusion he said he wondered what became of women fifty years ago, before the days of dilatation and contraction and other special treatment.

ST. LAWRENCE AND EASTERN MEDICAL ASSOCIATION.

A meeting of the members of the St. Lawrence and Eastern Territorial Division was held in Cornwall, January 27th, 1885. Present:—Drs. Bergin (chairman), McMillan, Brouse, Moore, Easton. Pickup, Pringle, Alguire, Munro, Harrison, Hamilton, Gravely, S. A. Hickey, G. C. Wagner, Davis, Reddick and Lefevre.

The chairman addressed the meeting upon the following subjects: the proposed increase of the annual fee to the Council, the advisability of raising the standard of medical education particularly in preparatory examinations, the Imperial Medical Act, the establishment of a code of ethics, and revision of the tariff.

The following resolutions were carried:—That in the opinion of this meeting it is not advisable that the annual fees should be increased to $5, as proposed by the Medical Council.

That this meeting disapproves of Universities and Colleges having no medical schools in connection with them, being represented in the Medical Council.

That this meeting approves of raising the standard of the matriculation examination. That candidates for matriculation should be obliged to present credentials of matriculation in arts from any Dominion University, which will entitle them to matriculate in medicine upon payment of fees.

That this meeting sincerely hopes and requests that the Medical Council will take such steps as shall forthwith give to this province a legal code of medical ethics.

That this meeting feels very strongly the injustice of being obliged to register Imperial graduates without examination, a privilege we deny our own graduates, and that we desire the Council to take such steps as may be advisable to obtain justice in this matter.

That it is desirable to have a taxing master appointed for each Territorial Division.

That the registered medical practitioners resident in the St. L. & E. Division do now form themselves into an Association, to be known as "The Medical Association of the St. L. & E. Division, the officers to consist of a president, two vice-presidents, a secretary and a treasurer; the president to be the representative of the Division in the Ontario Medical Council, and the other officers to be elected annually. The following were elected:—Dr. Bergin, President; Drs. Brouse and McMillan, Vice-presidents; Dr. Lefevre, Secretary; Dr. Moore, Treasurer.

A committee was appointed to revise the tariff, and their report being adopted, the Secretary was instructed to forward it to the Territorial representative, to be submitted by him to the Medical Council for approval at the June meeting.

J. M. LEFEVRE, M.D., *Sec.*

Selected Articles.

REVIEW OF THE GROWTH OF McDOWELL'S OPERATION IN 1809.*

BY R. S. SUTTON, M.D., LL.D., PITTSBURG.

In the bleak cold of a December day, in 1890, a woman riding on horseback, arrived in Danville, Kentucky. She had taken farewell, perhaps forever, of relatives and friends, and had just completed a journey of sixty miles that she might be near a surgeon, who had promised to open her abdomen, and endeavor to remove a large ovarian cyst it contained. She was to be the subject of an experiment—an experiment at the hands of a surgeon living on the borders of civilization—an experiment which would involve her life, and to which she must submit without the blessing of chloroform or ether. This woman possessed of marvellous courage was Mrs. Crawford, McDowell's first patient in ovariotomy, and the first patient on whom the operation was ever deliberately undertaken. She recovered and lived to the advanced age of seventy-nine years, a period of thirty years beyond the operation.

The conditions surrounding, and forming part of this operation, are worthy of more than a passing notice. At the present time, they are declared by the ablest operators to be of more than accidental importance.

In the light of all the recent advances concerning the environs of an ovariotomy patient, I ask you to listen thoughtfully, and inquire of yourselves: Have modern operators had better environments than McDowell? Is their quarantine better than his was? Whether accident, or necessity, or the simplicity of border life, provided these conditions so favorable to recovery, your orator will not inquire, but hopes to show that McDowell did operate under conditions as favorable as does Dr. Keith or Mr. Lawson Tait.

1st. The patient was refused operation in her own home.

2nd. She was operated upon in Dr. McDowell's own house.

3rd. History mentions but one assistant present at the operation.

4th. The patient had never been tapped.

5th. We may safely infer that the room in which the operation was performed, contained, at this early date in Kentucky, no superabundance of furniture or upholstery.

6th. That the room was ventilated by an open fire-place is more than probable.

7th. The atmosphere was that of a healthy border town.

8th. No sponges were introduced into the abdomen.

9th. He ligated the pedicle and dropped it in.

This operation will stand the criticism of the most exacting specialist of the year 1885, save in two particulars: viz., the ligature was not carbolized or scalded, the ends of it were left hanging out of the lower angle of the wound, and merely turning the woman on her side to permit all fluids to escape from the cavity of the abdomen was scarcely enough in that direction.

The incision was made on the left of the rectus muscle, but in his next case McDowell made it in the linea alba, between the umbilicus and pubis.

Pause a moment! Think; at the end of almost three-quarters of a century, the operation stands almost where McDowell left it, with one solitary exception, viz.. the ends of the ligature surrounding the pedicle are cut short.

Restless human nature, not satisfied sought other means of treating the pedicle, a review of which is fraught with good instruction. For eleven years the operation remained in the hands of McDowell, and he adhered to ligation of the pedicle, leaving the ends of his ligature hanging out at the lower angle of the wound. In 1820, Chrysmar, of Würtemburg, tied the pedicle in two portions, leaving the ends of the ligature hanging out at the lower angle of the wound. In 1821 Nathan Smith, of New England, tied the pedicle with "strips cut from a kid glove;" he cut the ligature off close to the knots, and dropped the pedicle into the abdominal cavity.

Neither Chrysmar nor Nathan Smith knew anything of McDowell's operations. Were the teachings of Hunter and John Bell working upon other minds, as well as upon the mind of Dr. McDowell? The last named sent to Mr. John Bell, of Edinburgh, an account of his cases. Mr. Bell being then in Italy, his colleague, Mr. Lizars, received the report. It is probable that this record was received in 1818. For six years Mr. Lizars kept it to himself. He attempted ovariotomy four times, and succeeded in one case, the patient surviving the operation seventy days. In one case he opened the abdomen by an incision reaching almost from the ensiform to the pubis, and thrust his hand into an empty belly. He requested every one of his students to put his hand into the abdomen, and finally exclaimed, referring to an army officer present, "Where is the military gentleman?" and had him make the same manual exploration. Mr. Lizars then closed the wound, *and it healed by first intention.*

Owing to the fact that Mr. Lizars's results were bad, twenty years elapsed before ovariotomy was again attempted in Scotland. In 1845, Dr. Handyside performed it. Another halt of seventeen years occurred, bringing us up to 1862, at which date but one success had been attained in Scotland.

* The Address in Obstetrics, Am. Med. Association.

In that year Dr. Thomas Keith did his first operation.

Let us now cease the pursuit of Dr. McDowell's operation, as it was reported to Mr. John Bell, which report the latter did not live to see.

Up to the year 1843, I find the records of only eighteen completed ovariotomies in America. In this year Dr. Alexander Dunlap, of Springfield, Ohio, and Dr. John L. Atlee, of Lancaster, Pa., did their first cases, the latter removing both ovaries. Eleven years later (1855), Dr. Kimball, of Lowell, began operating. These three are now the only living pioneers of the army. May they live long to enjoy the distinction!

The operations in the United States were already numerous, and the stability of the operation secured. This was before Sir Spencer Wells did his first ovariotomy.

It is estimated by Peaslee that up to the last quarter of 1863, over three hundred ovariotomies had been done in this country. At this date, Dr. Keith was only beginning in Scotland; the operation was performed for the first time in Russia, and was only a year old in Italy. Twelve years after the death of Dr. McDowell, in 1842, Dr. Charles Clay, of Birmingham, England, did the first operation in that country; prior to this time, Jeaffreson, Walne, King, and West had each removed by abdominal section, parovarian cysts. In 1851, Baker Brown began operating in St. Mary's Hospital, London; his results were not good, and the intense opposition of his colleagues drove him from the hospital; he then founded "The London Surgical Home," where his results compared favorably with those of any other surgeon of his time. *It was mainly due to his action that the practice of performing ovariotomies in large hospitals, where isolation is impossible, ceased.*

From Baker Brown, Nélaton learned the operation by personal observation, and returning to France, related, in a public lecture, how he had seen Brown do five cases, three of them in a single day; and thus through the influence of Brown on Nélaton, the opposition to ovariotomy in France was largely diminished. In 1854, Baker Brown taught Sir Spencer Wells the operation, and in 1857 Sir Spencer did his first operation. In 1864, according to Sir Spencer Wells, the operation was completely established in London, and, we may add with pride, in every country in the civilized world.

But while the surgical world recognized the operation, there was a diversity of opinion with regard to the treatment of the pedicle. From the date of Dr. McDowell's first operation up to 1821, when Dr. Nathan Smith operated, the ends of the ligature were brought out at the lower angle of the wound; Dr. Smith was the first to cut the ends off. For sixteen years after, no other method was offered. In 1837, Stilling of Cassel, in the province of Hesse-Nassau, Germany, used the cautery, and suggested stitching the pedicle to the wound.

Nine years barren of new suggestions again elapsed, when, in 1846, Dr. Handyside, of Edinburgh, Scotland, carried the ligatures through the cul-de-sac of Douglas into the vagina. In 1848, Stilling treated the pedicle outside of the peritoneal cavity. Two years later, in 1850, this method was inaugurated in London by Mr. E. W. Duffin. The introduction of the extraperitoneal method of treating the pedicle by Stilling, in 1848, began a long and serious conflict which has happily died out with the method. Maisonneuve, of Paris, in 1849, had twisted the entire pedicle in one case, and Martin of Jena, had stitched the pedicle to the wound. About this time Langenbeck stitched the pedicle to the wound, and covered it with the skin from the margin of the incision.

Eight years later, in 1850, Dr. John L. Atlee, of Lancaster Pa., introduced the écraseur to divide the pedicle. He was imitated by a number of prominent operators, notably by his brother the late Washington L. Atlee, Sir Spencer Wells, Dr. Keith, Professor Pope, of St. Louis, U. S., and Professor Billroth, of Vienna. This year proved unfortunate for the operation, for during it Mr. Jonathan Hutchinson invented the clamp which perpetuated the extraperitoneal mode of treating the pedicle. In 1860, Sir James Y. Simpson secured the pedicle within the cavity of the abdomen by acupressure needles passed through the abdominal wall. About 1865, Koeberle, of Strasburg, invented his serre-nœud, or wire constrictor, with which he grooved the pedicle prior to applying the ligature.

In 1864, Mr. I. Baker Brown, of London, reverting to Stilling, of Cassel, established the use of the cautery, *a method rejected in London, taken up by Dr. Keith, and now credited through him with the best statistics yet attained by any operator.* In 1868, Masslovsky, a Russian, amputated the pedicle by double flaps, one on each side, and stitched the flaps together. In 1869, Dr. McLeod, of Glasgow, Scotland, by means of two pairs of strong forceps, twisted the pedicle entirely off. During this year, Dr. Peaslee invented a scabbard and knife by means of which the pedicle was secured, the ligature traversing the scabbard. After forty-eight hours the ligature was cut by introducing the knife into the scabbard, when both ligature and scabbard were withdrawn. In 1870, Dr. Thomas Addis Emmett reported eighteen cases in which he had secured the pedicle by means of silver wire.

Up to the present year (1885), every conceivable thing has been done with the pedicle. It has been tied entire; tied in sections; been twisted off; burnt off; crushed off; cut square off; cut off in flaps; left inside; left outside, and then made to slough off. The extraperitoneal method of treating the pedicle is gone. The question is now resolved into the merits of the ligature

cut short, the Dr. Nathan Smith method, or the clamp cautery, as introduced by Mr. I. Baker Brown, of London, in 1864. If the clamp as devised by Mr. Jonathan Hutchinson was a bad instrument, and according to Mr. Tait, reduced the statistics that Sir Spencer Wells should have attained, it must have similarly affected the results of those who have employed it in the United States. Recently ligation and the cautery have given almost equal results.

The operation of Dr. McDowell in so far as it relates to the treatment of the pedicle, is, therefore, triumphantly where he placed it, despite the ingenuity of the surgical world, having undergone but a single alteration, namely, Dr. Nathan Smith's improvement of cutting the ligature short. I have not been able to learn anything as to the extent sponges were used by the pioneer operators. When Dr. Keith was about to do his first operation, he had the water to be used boiled the night before, and he made everything scrupulously clean; during the operation he was surrounded by old practitioners.

After removal of the cyst, he thrust a big sponge into the abdomen, and brought it out full of fluid. As he was about to repeat this, one of the doctors seized his arm, and exclaimed, "For God's sake don't do that again." While he hesitated, the others argued that any fluid left in the body would be a nice protection to the intestines. He closed the wound. Subsequently the patient did badly. He at once opened the wound and let out a pint of dirty fluid, and the patient recovered. From that time he advocated careful sponging after the operation, *and he was the first to insert a flat sponge under the wound while the stitches were being placed.* Koeberle, who also began to operate in 1862, *introduced the compression forceps and drainage, first by short and later by long glass tubes.*

I here show you the Baker Brown cautery clamp, used by Dr. Keith, the compression forceps of Koeberle, *also the modification of Sir Spencer Wells*, and the drainage tubes so much in use by operators in great Britain.

The technique of McDowell's operation is, probably complete, *and its future will depend on the subject, the place of application, and the care taken to protect the patient from extraneous sources of danger.* It may be compared to a mighty oak, each decade of years having added to its greatness until its far-reaching branches furnish shelter for the thousands of men and women who require abdominal section. Its ramnifications are hysterectomy for fibroids, hepatotomy, cholecystotomy, normal ovariotomy, the Hegar-Tait operation for the removal of both ovaries and tubes, nephrectomy, exploratory incisions, gastrotomy, and enterotomy. It still continues to grow, and the task of pointing out the leaves that have been added to its foliage during the last year requires our efforts ere they fall about the roots and contribute themselves to the growth of the parent tree.

Valuable lectures and papers have been given by Dr. Keith, M. Lawson Tait, Mr. Savage, Sir Spencer Wells, and Mr. Bryant, all in the *British Medical Journal.*

The results of valuable experiments on lower animals have been published by Prof. C. T. Parkes, of Chicago. Many successful cases of the Hegar-Tait operation done by our countrymen, and the surgeons of Great Britain, have been published in various journals.

Mr. Thornton has been successful in gastrotomy for the removal of a large foreign body, and has had seventeen successfuf cases of nephritic surgery ten of these being nephrectomy by abdominal section. Drs. Keith and Bantock continue to do supravaginal hysterectomy with unparalleled success, and it is premised that if their success continues, it will elevate their method of operating beyond the reach of controversy. They both adhere to the extraperitoneal treatment of the stump, while the continentals practise the intraperitoneal method.

The recent visit of Mr. Lawson Tait to the United States, has given great impetus to the Hegar-Tait operation for the removal of diseased tubes, and for the removal of ovaries and tubes for the cure of fibroids of the uterus.

For the purpose of encouraging the conservative abdominal surgeons, *those who look carefully to the environment of their patients*, I point with great pleasure to the fine statistics of Dr. John Homans, of Boston, and of Dr. Robert Battey of Georgia, whose early initiation of normal ovariotomy was suggestive eventually of the Hegar-Tait operation which included the tubes.

Ovariotomy and its offshoots comprise almost, if not the entire field of abdominal surgery. The The establishment of the parent operation brought out the others, if not for the first time, it revived and established them after they had been practically abandoned. "The seed sown by Bell and Hunter, carried by McDowell, and planted in Kentucky;" its first growth was slow, but gathering strength from the passing years, its top has risen high, and its great branches cover a wide space, where unfortunate men and women of every land and clime gather to find relief from suffering and to acquire new leases of life.

The carbolic spray is still a matter of dispute. In Great Britain, Mr. Thornton adheres to it as of old, Drs. Keith and Bantock, and Mr. Tait will have none of it. The latter said to me, "I sold out all my right, title, and interest in Listerism, with my tea-kettle to Battey."

So far as I know the best statistics yet obtained in ovariotomy in the United States belong to Dr. Battey, of Georgia, and Dr. John Homans, of Boston, Mass., both of whom operate under the carbolic spray,

and in apartments kept especially for abdominal operations. I make special mention of the fact that these gentlemen use the carbolic spray, for the reason that Dr. Emmett says in his last edition, p. 715, "I do not know of any prominent operator in this country who now uses the spray," evidently an oversight.

I do not use the spray myself, but look upon the entire Lister system, less the spray, as firmly grounded in the surgical mind. Cleanliness and Listerism can never be separated, for "Listerism is the gospel of cleanliness;" without the latter you cannot have the former.

The year has wrapped up in its eternal folds one whose name is synonymous with the surgery of women; whose reputation is immortal, who in America at least, stood next to McDowell; beloved by his own countrymen honored by the entire surgical world. No eulogy of mine can increase his fame. I speak of *the great, the good, the pure, the noble, the generous* Marion-Sims. Like McDowell, he possessed a genius for origination, and will share with him the admiration and plaudits of future generations.—*Med. News.*

HYPERTROPHY OF THE PROSTATE.

The gradual invasion of symptoms of urinary obstruction in a man of advancing age would always suggest the probability of hypertrophy of the prostate. But the existence of this condition may be demonstrated by a digital examination. The patient is placed in a supine position; the surgeon stands on his left side, and introduces at least two phalanges of his left index finger, slowly and gently into the rectum, while the patient's knees are flexed and separated from each other. The surgeon examines whether the enlargement involves one or both lateral lobes, equally or unequally, whether it affects chiefly the breadth or depth, whether it is soft or hard, regular or irregular, solid or fluid; whether fluctuation can be felt in the bladder behind the prostate. He should also examine as to tenderness on pressure, its degree and locality: he should also estimate the temperature of the parts. Prostatic calculi can sometimes be detected by the finger. While making these examinations with his left hand, he should introduce a catheter with his right hand, while the left index finger judges as to the thickness of the intervening tissues. The catheter should be of as large size as the calibre of the urethra will allow. If urine flows freely when the catheter has not penetrated more than 6½ to 7½ inches, and the handle is not much depressed, it is fair to infer that there is not much enlargement of the prostate. If the catheter has passed 8 or 9 inches, and the urine does not flow until the handle is considerably depressed, there is good evidence of prostatic enlargement. A prostatic catheter, longer than the ordinary catheter, and its beak nearly at right angles with its shaft, will be required, in such cases, to draw off the urine. Or a long soft catheter may be employed.

To explore the interior of the bladder, an instrument with a short beak, like Leroy's or Mercier's may be used.

Treatment.—There are three principal indications: *First.*—To obviate the results of obstruction. *Second.*—To improve the constitutional condition of the patient. *Third.*—To diminish the enlargement, or to retard its growth.

The first is the chief indication. The bladder should be evacuated as thoroughly as possible at least once in twenty-four hours. It is often desirable to do this three or four times a day. When the residual urine amounts to only two or three ounces, once a day may suffice. When it amounts to five or six ounces, the bladder should be evacuated at least twice in twenty-four hours. When the power of urinating is nearly lost, the catheter should be introdnced as often as the desire to void urine is felt. The patient should be taught to introduce the instrument himself. In determining the question as to the use of the catheter, the the degree of irritability of the bladder and of the urethra, and the acrimony of the urine are to be taken into account. When the urine is acrid and fetid, the bladder should be washed out with warm water, and with antiseptic lotions. The patient should be taught to use a flexible catheter, when it is practicable. But special care should be taken to avoid the use of flexible catheters which are worn or cracked, or which have their eyes deformed. The eyes of the catheter should be of full size, as the urine is often viscid, and will not flow through a small aperture.

But in some cases, a silver catheter must be used, and great care should be taken in instructing the patient, that he may do himself no injury. In using a flexible instrument a stilet six inches long may be used, stiffening the handle, but leaving the distal end flexible. When there is retention of urine, and the catheter is passed with great difficulty, it may be left in a number of days. The pressure of the instrument may, perhaps, cause some absorption of the hypertrophied part. To guard against the injurious consequences of non-evacuation or imperfect evacuation of the bladder, the use of the catheter is very important.

In cases in which treatment has been neglected and there is a very large amount of residual urine, a pint or more, it is not safe to withdraw more than half of it at once. From day to day, the quantity withdrawn may be increased, and, in the course of a week or two, the bladder may be emptied. The danger of the complete and sudden evacuation of the bladder under these circumstances was first indicated by Sir Benjamin Brodie.

When the disease has not advanced to the de-

gree which has been mentioned, there are certain complications requiring attention :

1st.—Atony of Muscular Coat of Bladder.—This is usually relieved in part by the regular use of the catheter. Other means may be of service. Cold applications over the abdomen twice a day. Cold injections into the bladder every day, or every other day. Electricity, strychnia, iron, ergot.

2nd.—Chronic Cystitis.—This is indicated by frequent and painful micturition, with pus and mucus in the urine. Relief is often afforded by washing out the bladder with warm water—100° Fahrenheit. The water may be introduced into the bladder by an India-rubber bag with a nozzle adapted to the catheter, or with a fountain syringe. But a more convenient instrument for the purpose is a hard rubber syringe, which has been constructed under my direction by Tiemann & Co., of New York, and which is known as Post's Vesical Syringe. It holds four ounces, and is of such a shape that it can easily be worked with one hand. Its distal extremity is adapted to a moveable tube, provided with a stop-cock, and tapering from a circumference of 30 mm. at the base to 10 mm. at the apex, so that it will fit a catheter of any size in ordinary use. Both ends of the syringe can be unscrewed, so that either end of the piston can be renewed by the surgeon without the aid of an instrument maker.

After the bladder has been washed out with warm water, mild astringent injections may be employed, such as mineral acids largely diluted; weak solutions of acetate of lead, nitrate of silver, etc. Hot hip-baths may often be used with advantage : also, hot fomentations over the abdomen. Counter-irritants are sometimes useful, as sinapisms and blisters. I have seen very great benefit resulting from the use of the actual cautery in the hypogastric region. Leeches may often be applied with great advantage, to the perineum or around the anus.

Internal remedies are often of service, such as diosma crenata, pareira brava, uva ursi, triticum repens, copaiba, cubebs, ol. santal, demulcents. Gross recommends highly infus. uva ursi and hops. Alkalies often have a very soothing influence even when the vesical urine has an alkaline reaction.

3rd.—Irritability of Bladder, with frequent painful micturition. Opiate suppositories are often useful. Ext. belladonna or hyoscyamus may sometimes be combined with it. Opiates may also be given by the mouth. Chlorodyne has been given with advantage. When there is phosphatic deposit, inject the bladder with weak nitric acid once in a day or two—one or two minims to ʒ j : quantity ʒ i j to ʒ iv. A solution of acetate of lead, gr. j to iv, to an ounce of water,—when urine is fetid, carbolic acid 1 per cent.

In cases of vesical hæmaturia, gallic or tannic acid may be given internally, gr. v or vj, ter. in die. Mineral acids. Ol. terebinth, x to xv, in emulsion. Sesquichloride of iron. When hemorrhage is alarming, a bladder filled with ice may be applied to the hypogastrium or perineum. Ice-water may be injected into the rectum, or ice suppositories may be used. A collection of blood in the bladder will often obstruct the eye of a catheter when the patient is in an erect posture ; but when he assumes a supine position, the blood will gravitate towards the posterior part of the bladder, and the urine will flow through the catheter. The attempt to break up the clot is likely to cause fresh hemmorrhage. When there is complete retention from a clot, and symptoms are urgent, Bigelow's or Otis' Evacuator may be employed. In extreme cases cystotomy may be resorted to.

Incontinence of urine may occur ; this is usually an overflow from a distended bladder, but there may be inability of the bladder to retain more than a very small quantity of urine. In either case, an India-rubber receptacle may be worn.

There is often liability to congestion and inflammation from slight causes, as exposure to cold, riding on horseback, journeying, sexual excitement, alcoholic stimulants, etc., giving rise to fever, gastric disturbance, muco-purulent or bloody discharge. Relief is afforded by warmth, rest in bed, laxatives and anodynes. In such cases, there should be great gentleness in use of catheter,—leeches around anus, dry cupping in perineum.

General Treatment of Patients with Enlarged Prostate.—Carefully guard against catarrh, indigestion or constipation. Diet carefully regulated—avoid indigestible food. Alcoholic stimulants should be altogether avoided or their use carefully regulated. Warm clothing, dry feet, warm foot-baths and general baths. Muscular exercise should not be neglected, but it should not be carried to such an extent as to produce great fatigue. When the patient is tired, he should rest in a horizontal position ; he should avoid despondency, and keep up his spirits by cheerful society, employment and recreation.

Special Treatment of Enlarged Prostate.—Medical treatment has not yielded very satisfactory results. Conium, different preparations of mercury and iodine, muriate of ammonia, and various mineral waters have been recommended, but none of these remedies seem to have exerted any remarkable influence in diminishing the bulk of the prostate, or in retarding the progress of the disease. The use of ergot by the stomach or by hypodermic injection has been recommended. Henry Morris, in a paper published in the *Lancet*, December, 22nd, 1883, states that he has seen great benefit from the use of ergot. Dr. Washington L. Atlee, in an article published in *N. O. Med. and Surg. Journal*, August, 1878, gives similar testimony. Under its use, several of his patients were able to dispense with the use of the catheter. He

gave 20 drops of the fluid extract every four hours, until a decided improvement took place, and then diminished the frequency, finally giving only one dose at night.

In the *Brit. Med. Journal*, 1878, vol. II, page 500. Dr. William Bird, of York, states that he has derived great benefit from the hypodermic injection of ergotine in doses of ⅓ of a grain.

Pressure has been recommended as a means of diminishing the bulk, or retarding the growth of a hypertrophied prostate, and the use of large catheters or sounds is probably of some service in this respect.

Electricity has been recommended, but it has not realized the expectations of those who have used it.

The removal of obstructing portions of the prostate by ligature, excision or crushing has been recommended, but there is a difference of opinion among surgeons as to the expediency of this method of treatment. Gouley recommends a median incision of the perineum, opening the membranous part of the urethra on a grooved staff, and introducing a catheter into the bladder. In a more severe class of cases, he recommends the ablation of the median prostatic outgrowth. He explores the prostate by introducing a finger through the perineal section, and if a median outgrowth or isolated tumor be discovered, he enucleates the tumor, or excises the outgrowth, or removes it with a wire écraseur. After the removal of the tumor, he leaves a catheter in the bladder a number of days. —*New England Med. Monthly.*

ON DIET IN DISEASE.

Dr. J. Milner Fothergill gives the following in the *Medical Times*, May, 2, 1885:

A patient amused me very much yesterday. She had been for some time getting weaker and thinner, with her liver out of order, while her medical man had been feeding her upon meat and giving her vegetable tonics and iron, but without good result. At last she suspected that the treatment did not suit her, and so consulted me. When asked to put out her tongue, she observed, "The other doctor never asked to look at my tongue." If he had, he might have been more successful with his treatment. "Has he been giving you steel?" I asked. "Yes, and it did not agree with my liver," she promptly added, evincing a shrewdness that took me aback. On vegetable tonics without iron, and much lighter food, she got on famously. Yesterday she called to report her improvement.

Some time ago, in conversation with the manageress of one of the many Homes now springing up where paying patients can be nursed, the subject of feeding sick persons cropped up, and she was very enthusiastic about "a twenty-minutes pudding," but of what it consisted did not transpire. A tentative remark about the digestion of the starchy materials of our food flew past her unheeded. It was soon clear that of any rational ideas of digestion, theoretically or practically, she was in unillumined ignorance: all she knew was a little empirical knowledge, and of that she did not possess a superabundance. Who then, is to know this matter of feeding? Who is to tell the student of the difference betwixt raw or uncooked starch and cooked starch?—that in the latter the insoluble starch-granule is not only cracked, but the starch is largely converted into soluble dextrin by exposure to heat? that by the addition of some such soluble carbo-hydrate to meat-broths they endow these broths with a decided food-value? and that the meat-broth itself is but an agreeable vehicle for some food? Yet this is what he ought to be instructed in, if he is to be fitted to meet disease. When the patient sinks of exhaustion, of what does he die? His stores of force are run out; but what is the material which constitutes the body-force? I should read with delight a lecture upon this topic by Dr. Austin Flint or Dr. Da Costa,—or perhaps some less illustrious physician will grapple with the topic. We know that when a patient declines all food he will die in a given number of days. If a healthy person be hungered, as by shipwreck, he also will live a given number of days. In the latter case death will come all the sooner if the surrounding temperature be low. In the former case the duration of life will be shorter as the body-temperature rises. There is a question of combustion involved. It may not be the whole question, but it is an important factor! Alcohol is a readily-combustible hydro-carbon: it is used freely in critical times. Does not the idea naturally suggest itself that somehow the store of glycogen—the body fuel—is a cardinal matter? If this be so, it is evidently desirable to keep up the stock of this material so that it may not be exhausted. If raw or uncooked starch be employed, probably it is little acted upon by the diastase of the saliva, or even the diastase of the pancreas, both organs being crippled by the general malaise. But a starch which has been rendered soluble by previous baking or by the matting process has been so modified that it is highly soluble.

I do not know how the matter stands in the United States, but as regards the mother-country, little, very little use indeed is made of those prepared foods spoken of—sometimes derisively—as "Baby-Foods," either in cases of primary dyspepsia or in that debility of the digestive organs which is involved in serious morbid conditions. Yet by the addition of cooked starch, as biscuit-powder, to meat-broth, and of malt preparations to milk or milk somewhat diluted with water, foods

nutritive and at the same time readily assimilable are furnished to the sick person. Of the advantage of a fairly competent knowledge of such foods, both in their chemical elements on the one hand and in their variety on the other, probably no one can be better aware than myself: and such knowledge has been of infinite service to me, or some grave delusion exists in my mind. We must, too, remember another aspect of the subject,—viz., variety. While we are in health we are apt to growl about lack of variety in our food: how much more, then, the sick man! If the changes can be rung by different forms of meat-broths combined variously with different prepared foods, how much variety can be furnished to sick persons, and with that how much inducement to take that nourishment, so badly wanted and so hard to supply in many instances! Sago, tapioca, and rice or barley can all be placed in a slow oven and baked for an hour without scorching, and so be prepared for use in the sick-room. When the patient is convalescing, a milk pudding can be prepared of such material, which requires but little of the digestive act. Or there are various forms of plain biscuits which are admirably adapted for use with broths or soups (the Channel Islanders always thicken their soups with biscuit broken fine or powdered). By such means a good and, indeed, substantial meal can be furnished to a phthisical person with softening tubercle and a feverish temperature,—a typical instance of enfeebled digestion due to general malaise. And as for gastric catarrh or atonic dyspepsia, such a meal would not be likely either to become enfolded in a layer of mucous or to present any difficulty as to solubility. These may seem very simple matters, scarcely worth putting on paper; but the professional acquaintance with them is not as ample as it might be with advantage to invalids and sick persons. When a medical man lifts his eyebrows or protrudes his lip when "Baby-Foods" are mentioned in relation to dyspeptics and persons acutely sick, the impression he makes on my mind is this: that he has not made a study of the matter of food and its digestion, and that he has yet to learn some matters which, when acquired, will enlarge his usefulness and strengthen his hands when he stands by the bedside of his patient.

DURATION OF CONTAGIOUSNESS IN INFECTIOUS DISEASES.

The only attempt within my knowledge to formulate experience in respect of the duration of infectiousness, is that of Dr. Miller, of Dundee, whose tabulation is as follows:

Small-pox—14 days after termination of scabbing.
Typhus—28 days from inception.
Scarlet fever—7 weeks from inception.
Diphtheria—6 weeks from inception.
Whooping-cough—8 weeks from inception.
Measles—6 weeks from inception.

Small-pox.—As to small-pox, there is practically unanimity in regarding the danger as existing until all crusts are removed; but a few incline to prolong even further the period of isolation.

Typhus Fever.—In relation to typhus, there is less accord. One deems fomites the most important factor in the dissemination of the malady, while the rest lay stress on personal contagion. One regards it as "not contagious after a short interval;" a second advises segregation until repeated baths have followed the complete disappearance of the cutaneous exanthem; a third, somewhat indefinitely, would permit return to school "after complete recovery and disinfection."

Typhoid Fever.—Those who believe in the direct personal contagiousness of enteric fever are few in number, and I fancy that nearly all of us will agree that the intestinal discharges are all with which preventive medicine has concern. Whether these retain their infectious properties during the whole process of the malady is a question still in uncertainty, and rendered more obscure by the apparent demonstration that the disorder may, under certain undetermined circumstances, be generated *de novo* from ordinary sources of filth-poisoning. At all events, isolation of the person seems unnecessary as soon as convalesence is complete.

The same considerations will apply, I believe, to cholera, with the further remark that, if Koch's recent observations are correct, the germs of this disease appear to be shorter-lived than any other known species, being destroyed not only by desiccation, but by the "scavenger-bacteria," which conquer them in the struggle for existence in the products of common decomposition.

Diphtheria.—Diphtheria affords a wider debatable ground. To begin with, there are many (among whom my own experience forces me to class myself) who assign the first place in the pathogeny of diphtheria to the filth-poisoning, and doubt its exceeding contagiousness. Of a number of persons exposed to the same pathogenic conditions, it is not surprising that several should succumb; but this is not convincing evidence of transmission from one to the other, and I have seen repeated instances where, despite intimate contact, the disease failed to extend after its introduction into places in proper sanitary condition. One of my correspondents, who has long had charge of a large hospital for children, believes this malady to be feebly, if at all, contagious, and finds it quite safe to remit quarantine "after the disappearance of membranes;" a practical sanitarian, of national reputation, excluding fomites and filth in air or water, does not believe in personal contagion; a distinguished teacher in one of our metropolitan colleges doubts "its communica-

bility, except by contact;" another, equally eminent, declares that contagiousness endures until the last trace of inflammation or infiltration secondary to the diphtheritic process has disappeared; a fourth would protract the duration of quarantine for a month, or at least three weeks, after all symptoms had abated, and would forbid return to school while any redness of the fauces or any coryza lingers. The discrepancy of opinions in this respect among the leaders of professional thought suffices to show the need of more definite data to guide our deliberations.

Whooping-cough. — In pertussis, all opinions agree, save one, that contagiousness ends when the cough loses its spasmodic character, the single doubtful view being that, as the danger is wholly from the breath of the patient, it cannot be determined how long the cough may convey infection. It should be remembered, however, that a few writers have expressed doubts of the contagiousness of pertussis in any stage.

Measles.—With regard to measles, I find equal diversity of views. One regards its contagium as very volatile, not long adhering to person or clothing, and permits the return of the patient to school in two weeks after convalesence; a second would defer liberation from quarantine until a week, at least, after desquamation; a third releases the patient when desquamation has ceased, or in cases where no desquamation occurs, after twenty-one days; a fourth fixes eighteen days; a fifth believes the danger past when the febrile stage and eruption are gone. The majority measure the time of isolation by the process of epidermal exfoliation.

Scarlatina.—In scarlatina, also, we have opposing opinions, ranging from that which considers it a pythogenic disease, slightly, if at all, contagious from the person, to that which holds the infection to be communicable by the pulmonary exhalations, the blood, the naso-pharyngeal secretions, even the urine, as well as by the epithelial scales. One of my correspondents thinks the infection remains so long attached to the person, that quarantine should endure for eight weeks; another cites an example of transmission after six weeks of isolation followed by a change of clothing; the rest concur in releasing the patient after desquamation has ceased and the surface been thoroughly cleansed. Most of us, I dare say, have adopted this "rule of thumb."—*N. Y. Med. Journal.*

ACTINOMYCOSIS.

Some incidental remarks made at a recent meeting of the Pathological Society revealed the existence of the first genuine instance of Actinomycosis in this country. The case occurred, we believe, in the practice of Dr. Harley at St. Thomas's Hospital, the post-mortem examination being made by Dr. Sharkey, and the miscroscopical examination by Mr. S. G. Shattock, curator of the musuem. As the disease in man has only been recognized within the past decade, and as no cases have hitherto been recorded in this country, it is not surprising that but few members of the profession in England should be acquainted with it. A valuable clinical contribution to our knowledge of the affection in man, has recently appeared from the pen of Dr. J. Israel.* In 1882, professor Ponfick published an almost exhaustive monograph on the disease, in which most of the facts then known were embodied. From questions which have been addressed to us, we believe that a brief account of the elemental features of the affection will be welcomed by the majority of the profession, to whom the malady is unknown.

The affection is presumably one which is dependent on the presence and activity of a micro-organism. The micro-parasite is a member of the fungoid class, and consists chiefly of a mycelium which divides in a dichotomous fashion, and gives rise by its spread from a centre to a radiate appearance, whence its name— actinomyces—is derived. The circumferential ends of the mycelial sprouts have a flask-shaped swelling. The little masses of felted mycelium may be recognized by the naked eye as sulphur-yellow bodies of about the size of a hemp-seed. The disease which this parasite is supposed to cause may develop in many parts of the body. The most common site appears to be the jaw and parts bounding the mouth. The affection in animals has long been known in this situation under various names, and has been regarded as a form of scrofula and as a new growth. It is believed that the parasite gains an entrance through the medium of a carious tooth, or some wound of the gum leading to the jaw bone. There is but little to be said of the morbid anatomy of the disease. A swelling forms in the jaw, and gradually increases in size. This tumor in its earliest stages may be punctured without any matter being let out, although it generally has an elastic and semi-fluctuating consistence. A section made into a tumor in the early stage of its existence shows a reddish-white area sprinkled in places with gold-coloured granules. Later on abscesses and fistulæ form, in the discharge from which sulphur-colored bodies may be seen. Broadly speaking, the tissue of the morbid new growth, which must be regarded as inflammatory rather than sarcomatous, has very much the characters of ordinary granulation tissue. Actinomycosis may occur primarily in the respiratory tract proper, and Dr. Israel makes this class of cases his second group. He narrates a case in which the disease was localized to the bronchial mucous membrane. The patient was a girl aged fifteen, who suffered from the signs and symptoms of chronic bronchitis,

* Klinische Beiträge zur Kenntniss der Actinomycose des Menschen. Berlin: A. Hirschwald.

with fetid expectoration, in which the actinomyces were readily discovered. Another case of a man, aged twenty, is given, in which the primary localization of the disease was in the parenchyma of the lung; it was afterwards propagated to the pleura and to the prævertebral tissues. Some of the cases have many of the clinical characters of empyema with discharging sinuses, and in such cases a complex system of fistulæ not unfrequently undermines the morbid tissues. The structures in the posterior mediastinum and prævertebral regions are often affected, and the bodies of the vertebræ may become carious. Dr. Israel makes his third group of cases include those in which the disease begins primarily in the intestinal canal. In some of the cases the foci of the disease are widely disseminated. The liver, spleen, muscles of the back, and muscular substance of the heart have been shown on post-mortem examination to have numerous centres of actinomycosis. Large abscess cavities may form behind the peritoneum as well as behind the pleura, and these may communicate by many perforations of the diaphragm. The symptoms necessarily depend chiefly on the localisations of the disease as well as on its rate of progress, and present therefore extremely varied clinical pictures. Dr. Israel's work contains an account of thirty-eight cases, which number includes all that have hitherto been recorded.—*Lancet.*

[Dr. J. B. Murphy, of Chicago, reported two cases in the human subject, before the Chicago Medical Society *(Chicago Medical Journal, March, 1885).* In both the disease attacked the lower jaw, and the peculiar sulphur-colored granules were readily recognized. Both patients recovered. These are probably the first cases which have been recognized on this continent]—ED. LANCET.

TREATMENT OF RINGWORM OF THE SCALP.—The following is a very simple and effectual method of treating ringworm of the scalp.

The child affected is made to sit down before a wash basin half filled with warm water. A folded towel is first of all tied around the child's forehead, in such a way that no fluid poured on the head can trickle into the eyes.

It is best to cut the hair short all round the affected part. If there be many spots of ringworm, the whole head may be closely cropped Have ready a two-ounce bottle of common spirits of turpentine, an ounce bottle of tincture of iodine, a camel's hair brush, and cake of 10 per cent. carbolic acid soap.

While the child bends forward over the basin, the spirits of turpentine is freely poured over one or more spots at a time, the forefinger being used to rub the turpentine well into the scalp. Almost immediately the dirt and greasy scabs disappear, and the short broken hairs are seen to stand up like bristles. Generally, in about three minutes time the child cries out "Oh, it nips!" and we know the turpentine has penetrated deeply. Immediately the piece of carbolic acid soap is rubbed well into the parts which have been acted on by the turpentine, and warm water is freely applied to make this soap into a lather, by which means the head is well washed, and soon appears to be beautifully cleaned. The smarting, such as it is, quickly disappears. The head is then well dried with a towel. Common tincture of iodine, in two or three coats, is now painted well over the affected parts, and allowed to dry. As soon as the hair is dry, some carbolic oil (1 in 20) is rubbed through the hair to catch such spores as may be there.

This treatment, applied every morning, or morning and night in very bad cases, generally cures the worst cases in the course of a week. During the last five years I have used no other method of treatment. The explanation of its success is as follows: common spirits of turpentine is a powerful germicide, but is a still more powerful solvent of of the sebaceous or greasy matter of the scalp, and it rapidly penetrates into all the epithelial structures of the scalp, the affected hairs included, and clears the way for a more powerful germicide, namely, the tincture of iodine.

It is an interesting chemical fact that spirits of turpentine, or more correctly, oil of turpentine, is a powerful solvent of iodine. This quickly destroys the fungus of ringworm. If tincture of iodine be applied to the spots which have been treated as above, first with the spirits of turpentine and then washed with carbolic acid soap and water, it finds its way down into the epithelial structures, and into the hair-follicles, following the course which the spirits of turpentine has taken It is of no use to apply watery solutions of germicides until the sebaceous or greasy matter of the scalp has been first removed.

In some severe cases I have used a solution of iodine in turpentine, ten grains to the ounce, instead of the tincture of iodine, after the head has been washed and cleaned; but in most cases the use of tincture of iodine, after the part has been acted on by spirits of turpentine as above described, is quite sufficient to destroy the disease.

Ringworm of other parts of the body may be treated with spirits of turpentine and tincture of iodine in the same way. One great advantage of this treatment is that it may be used on the head of the youngest child, and causes little or no distress at any time.—*Brit. Med. Journal.*

RAPID ANÆSTHESIA BY ETHER.—Dr. A. F. Müller says in the *Med. News* April 4th: "The following method of rapid anæsthesia by ether was suggested to me seven or eight years ago by a thought that the great length of time often consumed in

etherizing patients was due to the fact of the frequent interruptions necessary to replenish the cone or towel used for the purpose, and the consequent partial recovery of the patient. To obviate the difficulty and obtain a continuous flow of pure ether vapor, I have made an apparatus, consisting of the two valves of a rubber football sewed together at the edges and connected by a tube with a bottle containing ether, which is plunged into a bucket of hot water. Ether boils at 98°, and vapor passes over steadily and rapidly, and is inhaled by the patient, whose face is covered by the inhaler, protected by a clean towel.

The result has been surprising, as will be seen by the following cases, all etherized by this method within the last three months at the Germantown Hospital. In none of the cases was there nausea previous to anæsthesia; one at least came to the house the morning of the operation having eaten a hearty breakfast. In most cases no struggling, and if so, only slight; no stage of excitement. In cases that require only a few moments for operation, the patient wakes up as quickly as after nitrous oxide. After patient is etherized, the amount passing over can be regulated by a stop-cock at the bottle end of the tube.

The apparatus I have used is very crude, made only for the purpose of experiment, and I am having an improved one made, which I hope will be more satisfactory in its details."

The quantity of ether used to produce complete insensibility in no case exceeded three ounces; in some it was less than an ounce and a half. Dr. Müller reports 18 cases in which unconsciousness was produced in from 30 seconds to 2 minutes.—*Maryland Med. Journal.*

KUSSMAULS'S COMA.—Dr. Saundby read a paper on Kussmaul's coma before the Midland Med. Society, based upon two recent cases. He ascribed its symptoms, drawing attention to the peculiar character of the dyspnœa as constituting a distinguishing feature of pathognomonic significance. He especially insisted upon the fact that this form of coma was not restricted to diabetes, one of the cases related being an example of its occurrence in advanced renal disease. He referred to the various theories which had been advanced to explain it, and stated precisely the exact position of the acctonæmia question. He explained the methods used for testing the acetone, and showed Nobel's test with nitro-prusside of ammonia. In his opinion, the symptoms were due to the action of some poison nearly allied to acetone. He referred to Minkowski's suggestion that they might be the result of de-alkalization of the blood from the presence of some acid in great excess. After discussing the predisposing and exciting causes and the diagnosis, he pointed out that it was not invariably fatal. Treatment in the earlier stages should be elimatory, by purgatives, if the bowels could be got to act, and later on the intravenous injection of a neutral saline solution should be tried. The result in one case was to restore animation for the time; and where recovery was possible, more permanent results may be expected.—*Am. Med. Digest.*

RESECTION OF THE CLAVICLE FOR SARCOMA.—An interesting surgical case has been placed on record by M. Polaillon. The patient was a girl aged sixteen, in whom a swelling of the outer end of the right clavicle was first noticed eighteen months ago, and had gradually increased in size. There was not much interference with the movements of the arm, and but little pain. The tumour was about the size of the fist, of bony consistence, and lobulated in outline. The skin over it was normal. There were no signs of compression of the brachial nerves or vessels. The lymphatic glands were healthy. Careful examination showed that the tumour did not pass beyond the limits of the expanded clavicle in any direction. The operation was performed on Jan. 29th under the spray. A horse-shoe shaped incision was made through the soft tissues, and the flap turned inwards, its base being at the neck of the patient; the clavicle was cut through at the insertion of the sterno-mastoid in the inner third of the bone, and then disarticulated at its outer extremity. In order to isolate the tumour the fibres of the trapezius and deltoid were cut through at their insertion into the clavicle. Antiseptic dressings were applied. The patient did well, and left the hospital six weeks after the operation. There was but little deformity, and the movements of the arm were perfectly preserved. —*London Lancet.*

THE TREATMENT OF ASTHMA.—According to Dr. Rodet, the best means of overcoming a paroxysm of asthma consists in subcutaneous injections of morphia and inhalations of iodide of ethyl. Twelve drops of the latter, poured on a handkerchief and inhaled, procure almost immediate relief. The different papers and cigarettes which have been recommended are worthy of a trial, a change of air and occupation is often essential. In catarrhal asthma, the treatment must be directed against the bronchitis and laryngitis, which are often benefited by a stay in a warm climate. According to M. Hardy, very good results are sometimes obtained by means of a blister applied to the thighs or arm. In nervous asthma, bromide and iodide of potassium are the most useful remedies, especially the latter. Gymnastics and baths of compressed air can also be recommended.—*Journal de Medecine de Paris*, No. 25, 1884.

THE AFTER-TREATMENT OF SCARLET FEVER.—Mr. George Smith, of Somerset, England, in a

short note on this subject in a recent number of the *Bristol Medico-Chirurgical Journal*, gives a plan of treatment of the desquamative stage of scarlet fever which has been quite successful in his hands, and which might be followed with good prophylatic results in every case. It is well known that in this stage there is very great danger that the disease may be conveyed from a patient to a healthy person, even several hundred miles away.

To obviate this danger, he has been in the habit for several years of having his patients sponged over the whole surface of the body twice daily. The sponging is begun, as a rule, about a week after the appearance of the eruption, and is continued until the desquamative stage is completed. The material with which the patient is sponged is a mixture of one ounce of oatmeal to one pint of boiling water; this solution should be made fresh each day, and used while tepid, or at such a temperature as may be comfortably borne by the back of the hand. The gluten of the oatmeal sticks the scales of the skin to one another and to the surface of the body, which allows of their removal without the usual risk of infecting the atmosphere or clothing; thus greatly lessening the risks of spreading the disease. The gluten also fills the cracks in the new skin and protects it from the cold; which diminishes the risk of the œdema which so frequently follows scarlatina.—*Am. Med. Association—Journal.*

NAPHTHOL FOR ITCH.—Prof. Hardy publishes the following formula in the *Union Medicale*: Naphthol, 10 parts; vaseline, 100 parts. The powdered naphthol is to be dissolved in half its weight of ether. This solution is to be mixed with a portion of vaseline, and heated to 30° or 40° C., until the ether has been entirely evaporated, when the rest of the vaseline is to be added, and the mass carefully triturated. The homogeneous ointment thus obtained is to be kept from the access of air. It may be applied at any stage of itch, and whether it is or is not complicated with other eruptions. The duration of the treatment varies from 10 to 15 days.—*Med. and Surg. Reporter.*

A NEW TREATMENT OF EPITHELIAL CANCER.—Experiments now in progress, under the supervision of Dr. J. E. Garretson, at the Oral Hospital of this city, show a wonderful curative value in the treatment of epithelial cancer with the use of epiderm secured from the horse by means of a curry-comb, the treatment being nothing more complex than keeping a sore continuously covered with the ash-colored powder thus obtained The horses are to be washed over night and curried with new curry-comb in the morning. After pick-out the hairs the powder is ready for use. When horse epidermis is not to be obtained., the scales may be scraped by means of a knife-blade from the human arm or leg.—*Med. and Surg. Reporter.*

STRICTURE.—In urinary obstruction, due to prostatic hypertrophy or thickening of the mucous membrane of the urethra, Professor A. B. Palmer says that relief can frequently be obtained, and the evils of catheterization avoided, by simply making the stream of urine act as a hydrostatic dilator in its passage. This can be readily done during micturition by compressing the urethra between the thumb and fingers so that no urine can escape. An effort is to be made at the same time to forcibly empty the bladder. The result is that the urethra is gently and uniformly distended without pain. This distension can be obtained and sustained at will, and in a majority of cases, if daily repeated, will soon be followed by the power of almost completely emptying the bladder, with a fair and often a full stream.—*Medical Bulletin.*

JABORANDI IN OBSTINATE HICCOUGH.—Pagenstecher (*Ctrlbl. f. d. ges. Thérap; Bull. gén. de Thérap.*) reports a case of hiccough which had resisted every known remedy, including the bromides, morphine, chloroform, and electricity. The patient's diaphrgam contracted in the most violent manner about twenty or thirty times a minute, and he had been unable to take any nonrishment for three days. After receiving four grains of jaborandi-leaves, in the form of a decoction, he had a profuse perspiration, after which the hiccough was completely checked.—*New York Med. Jour.*

To render blood more coagulable—when we have effusions of the same into cavities and so cannot ligate the bleeding orifices, Prof. Gross advises—

℞.	Acid . gallici.	gr. ij	
	Digitalis foliorum,		
	Ergotin., *aa*	gr. j	
	Opii,	gr. ss.	M.

SIG.—Ter die.

When the stomach is irritable, so that medicines cannot be retained, and if it should be necessary to purge the patient, Prof. Gross recommends the following injection, should there also be much tympany: Oil of turpentine, ℥ss, rubbed up with the yelk of one egg, then add castor oil, ℥iss, warm water, Oj. To be used as an injection.—*Col. and Clin. Record.*

PRURITIS ANI and the distressing itching of urticaria and mosquito bites can be much alleviated by local applications of methol. It may be used by rubbing the methol pencil lightly over the surface, or by dissolving a small amount in alcohol and bathing the part.—*Lancet and Clinic.*

LITTLE BOY: "Please I want the doctor to come and see mother." Servant: "Doctor's out. Where do you come from?" Little Boy: "What! Don't you know me? Why, we deal with you. We had a baby from here last week!"

THE CANADA LANCET.

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THE AMERICAN MEDICAL ASSOCIATION

The thirty-sixth annual meeting of the American Medical Association was held in New Orleans April 28th and following days, under the presidency of Dr. Campbell, of Augusta, Ga. Although the attendance was not as large as was anticipated, the meeting was, upon the whole, a very interesting and profitable one. The address of the learned President was an able effort, and was listened to with profound attention. He referred to the honor conferred on the State he represented, and eulogized the long list of illustrious men who had guided the destinies of the Association, making special reference to Gross, Sims and others. He also paid a high compliment to Dr. N. S. Davis, of Chicago, who is generally regarded as the father of the Association, and who has faithfully watched over its interests for many years. He also alluded to the assured and satisfactory success of the *Journal of the Association.* He next referred to medical politics, so to speak, such as forensic medicine, the medical witness, the medical expert, etc., and suggested that a new Section should be formed, to which all papers, questions and reports in regard to the relations of medical men to legal tribunals might be referred.

The address on medicine was delivered by the chairman, Dr. Didama, of Syracuse, N. Y. Instead of giving a summary of the progress of this department during the past year, as is required by the by-laws, he alluded to two topics merely as having acquired special prominence, viz: the comma bacillus and cocaine. In speaking of the relation of the former to cholera he made a remark which we are sure all will endorse, "The results of Koch's experiments were negative so far as treatment was concerned, but let us labor and wait, and in the meantime direct a little more attention toward prophylaxis and therapeutics." The subject of the address on obstetrics by the chairman, Dr. Sutton, of Pittsburg, Pa., was "The History of Ovariotomy." This address is published in the present issue of the LANCET, and will be found very interesting and instructive reading.

The presentation of the report of the Committee appointed last year to make arrangements for the forthcoming meeting of the International Medical Congress in 1887, occasioned some lively discussion. The objections urged were that several "new code" men had been appointed to important positions as officers of the Congress and its sections, and that several States and Territories in the South and West were entirely unrepresented. The result was the appointment of thirty-eight additional members to the original Committee, with power to revise and correct the list of officers previously announced. It is to be hoped that the action of this monster committee will not jeopardize the success of the Congress. The *Boston Med. and Surgical Journal* in commenting on the action of the association says that the Congress is "more interested in medical science in the abstract than in local medical politics," and "that the "new code" nonsense had best be allowed to pass into ready oblivion, and not be given fictitious importance by further discussion."

The report of the committee on publication showed that the "Journal" was free from debt, had about 4,000 subscribers and promised soon to be the foremost in the United States. Dr. Davis of Chicago, was unanimously requested to continue as Editor. The social side of the meeting was all that could be desired. The members enjoyed the generous hospitality of their chivalrous brethren in the South to the full. His many friends in Canada will be pleased to learn that Dr. Brodie of Detroit, has been chosen president for the ensuing year. The next meeting will be held in St. Louis, on the first Tuesday in May 1886.

MISDIRECTED UTERINE EFFORT.

Every experienced accoucheur has met cases of misdirected uterine expulsive force. Two recent cases of this nature which have come under our observation, are the occasion of the following remarks. In both cases the women had borne several children. Labor in each case had always been both protracted and severe, continuing from twenty-four to forty-eight hours. Medical aid had invariably been called. In both cases, on arrival, the os was found fully dilated. The presentation was normal, and the head engaging the upper strait. The pelvis, in each case, was roomy and offered no unnatural obstruction. The pains were severe and attended with strong expulsive effort—in fact, of the character which usually marks the termination of a severe case of labor. A casual survey of the situation might easily have led to the prediction of a speedy delivery. A little waiting and a more critical examination, however, exhibited things in a different light. It soon became apparent that, notwithstanding the powerful uterine contractions, and the consequent suffering, little or no advance was made. From this it was evident that something was wrong. Placing the hand on the abdomen during the partial interval of pain, it was found to be prominent, and conical in shape, the apex pointing diagonally over the pubes. During a pain, this cone, with the hand resting on it, was carried forward over and beyond the pubic arch, thus doubling the fœtus upon itself, and showing that more force was directed to this point than to the outlet. Every obstetrician occasionally meets a case of which the above is more or less typical. The os is either dilated or dilatable; the presentation normal; the pelvis roomy, and the soft parts offering no apparent obstruction; the pains are severe, and the patient makes powerful expulsive efforts. All this, and yet hours of patient waiting and suffering are marked by no perceptible progress. The unfortunate woman is in great agony, and nature is fast becoming exhausted. Friends are in despair, and demand that "something" be done. The situation is a trying one to all concerned. Of course these remarks apply more or less forcibly to all cases of protracted labor irrespective of cause.

Having discovered the cause of delay, the next thing to do is to find and apply a remedy. Chloroform, morphia, and chloral, as everybody knows, are all agents well fitted to relieve the suffering and also to promote normal uterine contraction, where there is a deviation from this condition. In the cases under notice, chloral was the agent selected. About twenty grains were administered the first dose, and ten grains at regular intervals afterwards. A sheet was folded to the width of an ordinary abdominal bandage. This was passed under the patient, and crossed over the abdomen. The upper end was handed to the nurse, sitting at the opposite side of the couch, while the lower end, which embraced the *cone*, was held by the accoucheur. The nurse was directed to make no traction, but simply to retain a firm hold. The force exercised consisted mainly in *resisting* the downward and forward movement of the prominent uterine segment or cone. The pains, which had been insufferable, and without distinct interval, became more tolerable, having intervals so well marked as to permit quiet and needed sleep. The woman, who a little while before was in the utmost agony and despair, was now quiet and hopeful, and thus the case rapidly progressed to a happy termination. In each case the duration of labor was reduced to less than one-third that of former labors.

These cases are not presented on account of anything striking or novel, nor yet on account of the line of management pursued. The object rather is to put the profession in remembrance of the great fact that much can be done to shorten the duration of labor and to relieve the pangs of maternity. These surely are objects worthy the attention of every physician endowed with proper feelings, and no apology should be deemed necessary for even a frequent reference to them.

FOOD FOR INFANTS.

The many predictions concerning the possible advent of cholera during the present summer, are receiving due attention from medical men and boards of health in our large cities, and the result of such attention cannot fail to prove highly beneficial to the public health. But should we have a very hot summer, as is not improbable, there will be the usual "Slaughter of the innocents," in the large cities, and we think it important that the attention of the profession should be called to the

fact that three-fourths of the cases of sporadic infantile cholera are initiated by carelessness in the selection of the food given to bottle-fed infants. If from the first of June to the first of October every mother would see to it that her infant was fed with easily digested and in every respect suitable food for hot weather, we believe we should have to record at the close of this much dreaded summer a decrease instead of an increase in infant mortality.

Dr. H. Von Ziemssen, writing on *Sporadic Cholera*, in Vol. vii. of the Cyclopedia of Medicine, says :—"Regulation of the diet constitutes in fact the principal method of treatment of sporadic cholera and particularly cholera infantum. When mothers' milk is insufficient Liebig's Food or Nestle's Lacteous Farina are *alone to be recommended.* The latter is *especially* commendable because the physiological relations of the infantile digestive organs, particularly the lack of notable salivary and pancreatic secretions are taken into account in this fabrication, the starch contained in it having been transformed into dextrine." It should also be borne in mind that infant foods are also well adapted to the nourishment of invalids of all ages.

RAREFIED AIR IN PHTHISIS.

Experiments have been made from time to time in order to determine the effects of rarefied air upon respiration. The results generally show that an elevation sufficiently great to cause a diminution of the barometric pressure to one-third of its normal value is necessary to produce the desired effect upon the respiration, viz : to render it more frequent and profound. Experiments have been made with dogs by subjecting them to great variation of air pressure ; but no change in the respiration was observed until a height was reached which showed considerable rarefaction of the air. It would thus seem that the influence of mountain air on the respiratory apparatus, which some physicians covet for their consumptive patients, is not very decided until heights of at least 5,000 or 6,000 feet are reached. An interesting result obtained by these experiments was that at very low pressures (about ten inches of mercury) the ultimate effect was a diminished nutrition of the tissues.

The results are of value in determining the curative properties of mountain air upon weak and diseased lungs. But they are far from conclusive. Similar experiments were made in 1880 by Dr. Marcet with himself and a scientific companion at Courmayeur (3,945 feet) and the Col du Géant (11,030 feet high). In ascending from Yvoire to Courmayeur—a vertical distance of only 2,715 feet —the relative atmospheric humidity was lowered by 31 per cent. for the higher station, and the mean weight of the carbonic acid expired by the two experimenters was found to be in excess at the higher station over the lower by more than 8 per cent. This clearly shows the influence of even moderate altitude above sea level, coupled with increased atmospheric dryness, towards promoting combustion in the human body. At the high station of the Col du Géant, over 11,000 feet, the rate of breathing was accelerated by more than 39 per cent. in Dr. Marcet's case, and over 25 per cent. in his companion's. Although in the rarefied air of high levels the body makes more carbonic acid, it exhales it much more rapidly than under the lower pressure of the plains, and the augmented activity of the respiratory organs necessitated by breathing rarefied air is in many cases the chief curative agency of mountain districts.

ONTARIO MEDICAL ASSOCIATION.—The Association is to be congratulated on the large number of papers promised for the meeting in London on the 3rd and 4th inst. In fact it will scarcely be possible to get through with them in two days. In addition to the special subjects in medicine, surgery and obstetrics referred to in our last issue, the following papers are announced: Drs. Buck—"Sanity ;" Bray—"Cæsarian Section ;" Edwards —"Placenta Previa ;" Beemer—"Brain Exhaustion ;" Waugh—"Infantile Paralysis ;" Fraser—"Continued Fevers ;" Penwarden— ———— ; Graham—"Mitral Stenosis ;" Groves—"Urinary Calculi ;" Arnott—"Diet in Disease ;" Campbell —"Locomotor Ataxia ;" Ovens—"Trifacial Neuralgia ;" McKechnie—"Pericarditis ;" McLay—"Cystitis ;" Harrison—"Foreign Bodies in Larynx;" Aylesworth— ———— ; Moorhouse—"The Germ Theory with specimens ;" Worthington—"Lingual Neuralgia ;" Duncan—"Warburg's Tincture in Canadian Practice ;" Murray—"Uterine Hemorrhage after Abortion ;" White—"Straight Splint in Treatment of Fractured Elbow of Childhood ;"

added, is recommended in the treatment of inflammatory conditions of the nose and throat, with profuse muco-purulent secretion. Crusts that may be present and tenacious mucus should be removed from the surfaces, which should then be sprayed with an atomizer provided with suitable tubes. Dr. J. N. Mackenzie regards it as a most valuable disinfectant in ozœna and fœtor of the breath from pharyngeal disease. He found it successful in his own case in abating an acute coryza, and had good results in treating chronic nasal catarrh.

NEW YORK POLYCLINIC.—The Winter Session of the New York Polyclinic ended on Saturday, May 30th. The number of physicians who have attended the clinics since Sept. 22nd, is over 200. The Summer Session opens Monday June 1st, and will continue to Sept. 12th. The following clinics will be held each week: Gynæcology 12, Disease of Children 6, Surgery 8, Diseases of the Skin 6, Diseases of the Chest, General Medicine and Diagnosis 6, Diseases of the Eye 6, Diseases of the Throat, Nose and Ear 6, total 50. In addition Obstetric cases will be given to the class and a course in urinary analysis. The Laboratory of Pathological Histology will be open all Summer.

ATROPINE IN EPILEPSY.—David (*"Lyon méd."*) *N. Y. Med. Jour.*, administers to epileptic patients twenty grains of bromide of ammonium, and at the same time gives fifteen thousandths of a grain of sulphate of atropine night and morning. After this treatment has been continued for six months, he directs that two of the following pills be taken daily for at least a year:

Valerianate of zinc...	½ grain;
Extract of belladonna.....	1/10 "
Arsenious acid.....	1/10 "
Extract of gentian.....	q. s.

TONIC AND DIURETIC.—The following has been highly recommended in anasarca and other affections demanding similar treatment:

℞	Ferri sulph. . . .	ʒi.
	Pot. acetat. . . .	ʒij.
	Sq. scillæ. . . .	℥ss.
	Ext. digitalis fld. .	ʒi.
	Spt. juniper, co. ad	℥viii—M.

Sig. A tablespoonful in a little sweetened water three times a day.

PNEUMOTHORAX FOR HÆMOPTYSIS.—At a meeting of the Clinical Society of London, Dr. Cayley, reported a case of hæmoptysis treated by producing pneumothorax (*Lancet*, May 16th.) The patient was much reduced by repeated bleeding, and it was determined to admit air into the pleural cavity with the view of exercising atmospheric pressure and diminishing the circulation through the collapsed lung. The hæmorrhage was arrested, but the patient was too much reduced, and died of syncope, on the fifth day after the operation.

UNIQUE CASES.—Dr. Belfry of London, Ont., reports the case of a child which weighed 18½ lbs. at birth, and measured 23¾ inches in length. He also reports the case of a women 42 years of age, now at the menopause, who is cutting two new incisor teeth. Her permanent incisors decayed and were extracted last year. She is a weakly woman; had a tumor removed from the abdomen 15 years ago in Manchester, England, and a discharging sinus has continued ever since. She is also suffering from caries of the os innominatum. Both cases are unusual if not unique.

MELLIN'S FOOD.—Among infant foods which have become popular with the profession may be mentioned Mellin's Food. The manufacturers, Messrs. Doliber, Goodale & Co., of Boston, are to be congratulated on the recognition of their exhibit of this Food at the New Orleans exhibition, the judges awarding it the first prize, a gold medal, as the best food for infants and invalids.

CHOLERA INOCULATION.—It is reported that between four and five thousand persons in Valencia, Spain, have been inoculated with cholera microbes by Dr Ferràn. The results are said to have been successful, and the epidemic is disappearing. A commission has been appointed by the British Government to investigate Dr. Ferràn's experiments.

INTOLERANCE OF POTASSIUM IODIDE.—Many persons are entirely unable to take even very small doses of iodide of potassium, without producing unpleasant effects. To overcome this it is recommended to combine with it ordinary doses of fluid extract of belladonna. The addition of a small quantity of fluid extract of liquorice will also cover the taste and render the mixture more palatable.

CROTON CHORAL HYDRATE.—This remedy, for-

merly so much relied upon in the treatment of painful affections of the 5th nerve, is now much used in the treatment of neuralgic dysmenorrhœa, sciatica, lumbago, etc. Five or six grains in glycerine and water may be given three times a day.

VOMITING OF PREGNANCY.—The application of ether spray over the epigastrium is recommended in the vomiting of pregnancy. Immediate benefit has been derived from its use where drugs of all kinds have failed to afford relief.

CORRECTION.—In our April issue, page 239, the address of J. Ellwood Lee, manufacturer of Levis' Splints, was incorrectly given. It should have been *425 Walnut St.*, Philadelphia.

TRINITY MEDICAL SCHOOL.—The Fellowship Diploma of Trinity Medical School has been formally recognized by the Royal College of Physicians, London, Eng., and also by the "Triple" Examining Board of Edinburgh. This Diploma is now recognized by all the licensing bodies in Great Britain.

The death of Prof. Henle, of Berlin, the celebrated anatomist and physiologist, on the 18th ult. at the advanced age of 74 years, is announced. Also Prof. Panum of Copenhagen.

CORONER.—Dr. G. H. Bowen, of Seeley's Bay, Ont., has been appointed Coroner for the Counties of Leeds and Grenville.

We regret to announce the death of Mrs. Dr. Workman of this city, at the age of 72 years.

This estimable lady sustained the sacred and endearing relationship of wife and mother, for nearly half a century, and embellished a life devoted to its duties with all the graces of the Christian character. Dr. Workman has our deepest sympathy in his great bereavement.

Books and Pamphlets.

INHALATION TREATMENT OF DISEASES OF THE ORGANS OF RESPIRATION. By Arthur Hill Hassall, M.D., Lond. Longman & Green, London. Hart & Co., Toronto.

Dr. Hassall of San Remo, in the Western Riviera, has in the above volume furnished the profession with a succinct, but sufficiently exhaustive notice of the various requisites to be fulfilled by the very numerous forms of Inhalers that have from time to time been placed in the market, as also of the adaptability of the inhalation treatment for certain diseases of the organs of respiration. The subject is treated in seven chapters under the following heads: 1. Entrance of medicaments into the organs of respiration. 2. Principles concerned in the volatilization and inhalation of the medicaments. 3. The apparatus to be employed. 4. Inhalation chambers. 5. The quantities of the medicaments, the manner, frequency and duration of the inhalations. 6. The medicaments employed in inhalation. 7. The various diseases in which benefit may be expected to be derived from this mode of treatment. At the Continental spas it would seem to be the practise to make extensive use of inhalation chambers, the apparatus for which the author describes as also the various substances used for sprays and vapors, in which chambers the patients will remain for hours, breathing the artificial atmospheres. The work is a valuable addition to the literature on the subject

A PRACTICAL TREATISE ON DISEASES OF THE EAR. By D. B. St. John Roosa, M.D., LL.D., Prof. of Diseases of the Eye and Ear, New York Post-Graduate Medical School, and President of the Faculty; Surgeon to the Manhattan Eye and Ear Hospital. New York: Wm. Wood & Co. Toronto: Williamson and Co.

We are pleased to receive the sixth edition of this standard work on the ear. The author is well known as a specialist on the ear, and the previous editions of his work have been greatly appreciated by the profession. The edition before us has been revised with great care, new matter has been added and the work contains much information of value to the general practitioner. We have great pleasure in recommending this book to our many readers, as a reliable guide to the diagnosis and treatment of affections of the ear.

A GUIDE TO THE DISEASES OF CHILDREN. By James F. Goodhart, M.D., F.R.C.P., Assistant Physician to Guy's Hospital. Philadelphia: P. Blakiston, Son & Co. Toronto: Hart & Co.

The scope of this work may be defined by the following extract from the author's preface: "I have not considered it my function to write a book on general medicine, but so far as possible, I have kept in view the diseases which seemed to be incidental to childhood, or such points in disease as appear to be so peculiar to, or pronounced in chil-

dren as to justify insistence upon them." In the second chapter will be found valuable hints for the young practitioner on the diet of children in health, as also in the third chapter for the treatment of derangements arising from faulty diet. The fourth treats on acute and chronic diarrhœa. The author impresses on the reader the importance of never missing an opportunity of examining the alvine evacuations, as the appearances will give valuable suggestions for treatment. The fifth treats on stomatitis, thrush, cancrum oris. The sixth on diseases of the digestive tract. The remaining chapters, forty-eight in all, deal with the various diseases of infancy and childhood in a manner at once interesting and instructive. Unqualified admiration must be expressed for the ability exhibited in arrangement, and for the clear and attractive form in which the author has placed his views before the reader.

THE ANNUAL AND SEASONAL MAPS OF THE UNITED STATES, by Prof. C. Denison, M.D., Denver, Colorado. Chicago: Rand, McNally & Co. Size of map 58 x 41. Price, mounted on muslin, $5 00: on thick paper, $3.00.

These maps illustrate the climate, temperature, humidity, cloudings, direction of winds, and physical features of the country. They will be found invaluable to physicians and others who have occasion to recommend or take advantage of change of climate. All the mineral springs and health stations in the United States are also referred to in the tables. We recommend these maps to the attention of the profession in Canada.

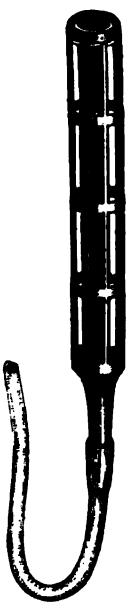
MEDICAL BOTANY OF NORTH AMERICA. By Lawrence Johnson, A.M., M.D. New York: Wm. Wood & Co. Toronto: Hart & Co.

The above-named work is a valuable addition to Wood's Standard Library of Medical Authors. As the title indicates the book treats principally of the botany of the plants whose therapeutic activity has placed them in the various text-books on Materia Medica. The work is illustrated with well executed coloured plates and wood cuts, and supplies a hitherto existing want, viz., a good manual on medical botany.

New Instruments.

COMBINED RECTAL AND INTRA-UTERINE IRRIGATOR.

Dr. J. S. Coleman, of Augusta, Geo., describes the following instrument in the *Brit. Med. Journal*, April 18th, '85:—In the *Medical Record* of New York, for May 10th, 1879, I presented to the medical profession the "Metro-clyst." I now desire to call attention to a modification of this instrument, which makes it available for the diseases of the rectum and surrounding pelvic structures. The instrument is of hard rubber, and consists of a cylindrical frame or cage traversed by a central tube. This arrangement insures the easy exit of the injected fluid. Any ordinary syringe can, by means of rubber tubing, be attached to it. My preference in the use of hot water is for the siphon. Thanks to the genius of Dr. T. A. Emmett, we all now appreciate the indispensable value of hot water, in inflammation and as an hæmostatic. Though I have not yet had an opportunity of test-



ing the merits of this instrument in ovaritis, pelvic cellulitis, or peritonitis, I feel confident that we will find it one of our most efficient measures in combating these serious and obstinate forms of disease. So far as I am informed, Dr. J. R. Chadwick was the first to advocate the rectal use of hot water in the treatment of pelvic inflammations (*vide* his able and interesting paper in the *Transactions* of the American Gynæcological Society for 1880). To me it promises much in acute prostatitis, inflammation of the rectum, and internal hæmorrhoidal troubles. I have had most gratifying success from its use in a case of puerperal endometritis, and in one of rectal ulcers.

Births, Marriages and Deaths.

On April 30th, H. K. Kerr, M. D., to Anna E., eldest daughter of F. Franklin, Esq., both of Hammond, N. Y.

THE CANADA LANCET.

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Original Communications.

INTRA-UTERINE MEDICATION.*

BY J. ALGERNON TEMPLE, M.D., M.R.C.S., ENG.

Prof. of Obstetrics and Diseases of Women and Children Trinity Medical College, Toronto.

It is well known to all the members of this Association that we are making a departure this year from our usual custom, and that instead of reading reports on the progress of the various branches of our profession within the past year, the chairman of each section has been requested to open a discussion in his special department, by choosing some subject for consideration. As chairman of the obstetrical and gynecological department I have selected for our consideration the subject of "Intra-Uterine Medication." It is not my intention to impose upon you any lengthy paper, nor do I intend to defend, or otherwise, this special subject; but merely to relate my own experience and pronounce my own judgment on this plan of treatment in certain uterine affections and thus draw from those present, interested in the subject, their own ideas and value of the procedure. I am well aware that this plan of treatment has its adherents, but it also has its opponents. There are some excellent men on our own continent who are strongly opposed to the procedure, while again in the old world some men equally good who are just as strongly in favour of this plan of treatment, and while I greatly respect both of these classes of practitioners, yet I unquestionably belong to those who believe in the great advantages of this plan of treatment in properly selected cases. To apply this system of treatment to all and every local uterine complaint is undoutbedly hurtful; to exclude constitutional treatment and depend entirely on local treatment is also wrong, the two plans of treatment should go hand in hand. That injurious effects have probably arisen in some cases I do not doubt, but at the same time I am disposed to attribute these bad effects to neglect of certain precautions and not to the plan of treatment itself.* The more clearly the subject is understood and the dangers known of the indiscriminate use of this plan of treatment, the greater will be the good results. The conditions most benefited are diseases of local origin, such as we see following abortions or confinement, the condition known as subinvolution, uterine catarrh, diseased conditions of the mucous membrane of the uterus, chronic endometritis, profuse and frequent menstruation, metrorrhagia, a large and flabby and relaxed uterus, cervical hyperplasia, cervical erosions, supersensitive condition of the lining membrane of the uterus, and uterine fungosities; while tumors and polypi and conditions depending on diseases of the Fallopian tubes and ovaries are not thus to be treated. I am quite satisfied that in all these diseases constitutional treatment is of the greatest importance and must not be neglected, but still it alone will not produce a cure; it is necessary to treat the diseased uterus locally.

We come now to consider the mode of applying the remedies. For the successful application of any remedy it is necessary that the cervical canal be sufficiently patulous to allow of the easy passage of a probe, armed with cotton wool, and saturated in the remedy, to pass through into the uterine cavity. In the diseases to which I have just alluded such is generally the condition, but if not it must be dilated first. Secondly, all mucous secretion should first be carefully removed from the uterine cavity so as to enable the remedy to come into direct contact with the diseased surface. And thirdly, no uterine inflammation or tenderness in the surrounding vicinity of the uterus should exist. First remove such tenderness by leeches, scarification, hot vaginal douches and rest in bed, and gly-

*Read before the Ontario Med. Association, London, June 4th, 1885.

* The reason assigned by those who do not approve of applications to the uterine cavity is that the mucous membrane is being constantly removed and renewed, and hence no good will come of applications. Such might also be said of the skin. Take a case of simple chloasma, because the epidermis is being constantly renovated are we not to treat this disease by local applications. So in cases of cystitis, the same thing would be applicable, and I might multiply such instances. To my mind it is not a sufficient argument against Intra-Uterine Medication.

cerine pads, and then proceed to heat the cavity. To apply any remedy to the cavity, I think the best position for the patient is on her side with nates near to edge of the bed, then having introduced a good large sized Sim's speculum into the vagina, the os is fully exposed to view; then lay hold of the anterior lip of cervix with a pair of vulsellum forceps and draw down the parts, pass a sound gently through the canal to ascertain its exact course, cleanse out the cavity with one or more of Playfair's probes wrapped round with cotton wool (absorbent), then take another, previously bent to correspond to the cervical canal, dip it in the solution you are about to use, and pass it directly into the uterine cavity as far as the fundus uteri, turn it round several times so as to touch the whole of the interior and leave it there for a minute or more. Be careful during this part of the treatment that the surplus fluid does not run down the vagina and over the thigh, as it will cause a good deal of pain and discomfort to the patient. Unless nitric acid or some such caustic is being used, it is not necessary to use a cervical speculum or protector, for what fluid is wiped off from the probe in its passage through the cervical canal is only enough to treat this part of the uterus.

Now, as to the frequency of these applications, I think once in four or five days for the alterative and astringents is enough, once in ten to fourteen days enough for the caustic ones. After the application the patient had better, as a precautionary measure, remain quiet for a couple of hours on her bed, though I am constantly in the habit of making such applications in my own office. It is exceedingly uncommon to find any unpleasant symptoms follow such procedure; for my own part I never saw an accident occur. I know it is reported that fatal peritonitis has followed this plan of treatment, and I am inclined to attribute such an unfortunate accident to the fact that the case was badly selected, that some low inflammatory state existed and was not detected, and that the case was not a suitable one. The remedies used are not many; some recommend them in powders, some in ointment, some inject them, while others again apply them by means of a Playfair probe dipped in the desired fluid; this latter is to my mind the best. I do not like the way of injection. I once or twice used that plan but gave it up long ago on account of severe constitutional disturbance. The remedies I most commonly use are carbolic acid (Calvert's No. 5), Churchill's iodine, iodized phenol, iodoform, nitric acid, and nitrate of silver. Undoubtedly many more might be added. The ones I mostly use of this list are carbolic acid and iodized phenol.

Nitric Acid is the strongest of them all, and should only be used for certain diseases; it is especially useful in the treatment of uterine fungosities, that sometimes obstinate disease to treat. Firstly, having dilated the cervix if requisite, and carefully scraped the whole surface of the uterus with the blunt curette, and then carefully wiped out the cavity, pass an armed probe previously dipped in the strong nitric acid through a cervical speculum into the uterine cavity. It is very necessary to use this useful little instrument so as to protect the cervical canal, otherwise sloughing and contraction might ensue subsequently. The vagina should likewise be protected by absorbent cotton dipped in a solution of carbonate of soda, so that if any acid runs out the vagina will not be injured. The application of this remedy to the uterine cavity is not painful nor have I seen any bad results ever follow its use. The patient should be kept quiet for two or three days in bed, and the remedy should not be applied again for ten or fourteen days. In the treatment of these growths I have seen the most excellent results follow; it is in fact, I think, the only condition calling for this strong caustic.

Carbolic Acid—This is a most useful remedy and one which I use largely. I find it especially useful in cases of uterine catarrh, and also in cases of tenderness of the inside of the uterine cavity. I am likewise in the habit of swabbing out the uterine cavity with this remedy after using the curette. Its action is slightly caustic and astringent and alterative. The preparation I am in the habit of using is Calvert's No. 5, simply because it is less caustic than the purer preparations. It causes very little pain, if any.

Iodized Phenol—Until I learned the good effects of this preparation, I invariably used Churchill's tincture of iodine, but of late I have quite abandoned it for this preparation. It was first introduced into practice by Dr. Battey of Georgia, and is made of one part of pure iodine to four parts of carbolic acid. This agent is particularly useful in cases of uterine hemorrhage, profuse menstruation, the result of imperfect involution, accompanied by

an unhealthy state of the lining membrane of the uterus, or in cases of menorrhagia, depending on the presence of vascular growths within the uterus. Dr. Battey likewise recommends it in malignant disease of the uterus, and Dr. Atthill speaks highly in its favor in malignant disease, for the purpose of both arresting the hemorrhage and progress of the disease; he however uses it by injecting ʒi of the solution once a week within the uterine cavity, and adds, no unpleasant results are likely to follow it when thus used, providing the cervical canal is patulous enough to allow the surplus fluid to flow back, and that it is injected slowly and not more than one drachm at a time. I have no experience in the use of this remedy in this form.

Iodoform I have used both in powder and crayons, but have not met with such good results from this remedy as to induce me to resort to it frequently.

Nitrate of Silver—I have introduced from five to ten grains of powdered nitrate of silver in cases of dysmenorrhœa, especially the membranous form, but it is painful and sometimes produces unpleasant symptoms, so I have abandoned it for safer and quite as good remedies.

I have thus very briefly brought before your notice this mode of treating uterine disease, and you will gather from the foregoing remarks that while I am a strong advocate for local uterine medication, I do not exclude the great advantages to be derived from general constitutional treatment, nor overlook the fact that uterine displacements, fibroid tumors and allied diseases, must receive appropriate treatment.

I do not intend that this paper should be considered in any other light than as the preliminary remarks to a general discussion on the advisability of Intra-Uterine Medication, and draw from those present an expression of opinion upon this very important subject.

CONTINUED FEVERS.*

BY A. S. FRASER M.D., SARNIA.

The continued fevers, which prevail at times in Western Ontario, are classified as typhoid fever, typho-malarial fever, and malarial continued fever.

In many localities, where continued fevers are common, cases of typhoid fever which run a normal course are comparatively few in number; much more frequently this disease developes in an irregular and uncertain manner, so much so that often a case of typhoid fever will have lasted for two weeks or more before satisfactory evidence of its nature can be obtained. In consequence of this, many cases of typhoid fever are called typho-malarial fever, although this term is usually applied to cases of continued fever which have many of the characteristics of typhoid fever, yet never show any symptoms of ulceration of the bowels. The name typho-malarial fever has been applied to a form of continued fever which is supposed to be either enteric fever modified by malaria, or malarial fever which has assumed a typhoid or adynamic form from some peculiarity of the patient. There are serious objections to both these views. In the first place, in well marked cases of the so-called typho-malarial fever, there is no reason to believe that ulceration of the bowels is present at any time during the whole course of the disease, as there is no tenderness nor fulness of the abdomen, neither is there any diarrhœa nor rose spots. In other respects the fever takes much the same course as typhoid, lasting from two, to eight or nine weeks; sometimes so severe as to prove fatal early in the third week; at other times showing only a slightly elevated temperature, with little prostration, lasting for four or five weeks, with a gradual return to health at the end of that time. There is seldom much dulness of intellect, and when delirium is present it is of a more active kind than that of typhoid fever.

In the second place, the reasons for believing that this fever is not of malarial origin, are these: 1st. Paludal malaria, which is the only kind of malaria we have to take into account, is developed under pretty well known conditions, and it has always been understood that severe malarial fever is the effect either of large quantities of malaria in the neighborhood of the persons attacked, or of an unusual susceptibility on the part of such persons to the influence of this poison. In either case the source of the malaria would be further from some than others, or some persons would be so much less susceptible to its influence than others, that milder forms of malarial fever, such as intermittent and remittent, would be found in the same locality as the more serious continued fever. 2nd. This

*Read before the Ontario Med. Association, London, June 3rd, 1885.

fever is frequently endemic when the temperature has been below the freezing point for several weeks, and the ground covered with ice and snow during that time, so that if malaria is the cause of the disease, it must have been latent in the persons attacked for some time.

Now it is a well known fact that malaria may remain latent and cause intermittent fever and other forms of malarial poisoning long after the individuals affected have been exposed to its influence; but there is no reason why such latent malaria should cause in a number of people, at about the same time, the most severe continued fever without manifesting any of its milder effects in other persons who have been living under the same conditions.

Most practitioners who have had much experience with continued fevers will agree that the so-called typho-malarial fever is difficult to separate from typhoid fever on the one hand, and malarial fever on the other. That its specific cause is probably similar to and exists under the same conditions as that of typhoid fever. Many will also concur in the opinion that typho-malarial is a term that is both inaccurate and misleading.

The following history will serve to illustrate the danger which may arise from the difficulty in separating malarial from non-malarial fevers. Waterworks were established in the Town of Sarnia in the year 1876. The supply pipe was placed in the River St. Clair, in close proximity to the outlet of a large sewer; but as the pipe extended for some distance into the channel, and the current was strong, it was not considered by those in charge of the work, that the water would be contaminated. It was noticed, however, that typhoid fever was more prevalent during the next two years than at any time before. In the spring of 1879, the supply pipe was broken by an ice jam; no attention was paid to the occurrence, and during the following summer, cases of continued fever became very numerous, many of them fatal. Unfortunately at the beginning of the outbreak the disease got the name of malarial fever. The water supply was, however, also accused of being the source of the trouble, and some samples of water, taken from the river and from hydrants in different parts of the town, were sent to Toronto for analysis. A report came back from Prof. Croft to the effect that the water was remarkably pure. This confirmed in their opinion, those who believed that the fever was due to malaria. The water pipe was repaired and extended for a distance of a hundred and twenty feet into a channel forty-two feet deep, in which the current ran four miles an hour. The number of cases of fever did not diminish in the least, and there was no doubt that a large proportion of them were uncomplicated cases of enteric fever of a severe type. The water was again analysed more than once and declared perfectly pure. The disease continued for four years, there being constantly present in the town from four or five to forty or fifty cases. Notwithstanding the fact that competent chemists had pronounced the water pure, there were many reasons for believing that it contained the germs of fever, and the town authorities finally decided to close the sewer which emptied near the waterworks, and to direct the sewage to a point some distance further down the river. This was done and the town at once became free from continued fevers, and the disease has very seldom occurred in the place since.

Concerning malarial continued fever, it may be said to have two characteristics which distinguish it from all other forms of continued fever. 1st. It almost invariably yields to sufficient doses of good quinine. 2nd. When a person has once been attacked by this disease he is very liable to subsequent attacks, the reverse being the case in typhoid and typho-malarial fevers.

THE EXTERNAL APPLICATION OF SULPHIDE OF CALCIUM IN SMALLPOX.

BY J. A. M'ARTHUR, M.D., C.M., WINNIPEG, MAN.

Several years ago, Surgeon-Major C. J. Peters, of the British army of India, experimented with sulphide of calcium as an external application in smallpox, and although the cases were few in number, six, I believe, yet such were the favorable results in each and every case, that he was induced to give an account of the treatment adopted. So favorably impressed was I with the success of the treatment, that I resolved to employ it, the first opportunity that occurred.

On the 10th day of April last, I was instructed by the Provincial Government to proceed to the town of Emerson and take charge of a case of smallpox that had recently broken out in that place.

The patient was a young woman, about 23 years of age, and previous to the present attack, was in good health. The form of smallpox was the confluent—the patient never having been vaccinated—and one of the worst cases I had ever seen. The day on which I first saw her was the 9th from the initial stage of fever and 3rd of the pustular stage. The face was terribly swollen and she was unable to see. The conjunctivæ, mucous membrane of the mouth and the tongue were thickly covered with pock. The face, neck, arms and limbs as high up as the knees were literally covered, so much so, that a pin-head could not be put down without touching them, while on the backs of the hands and soles of the feet blebs as large as a half-dollar piece could be seen. There was low muttering delirium, and the symptoms present indicated extreme prostration and a speedy termination of the life of the patient.

Feeling that this was an almost hopeless case and one which would test to the utmost the merits of any remedy, I determined to apply the sulphide and watch the results. The patient's face, neck, arms to the elbows and limbs to the knees were painted twice daily. The application was made with a brush and not with a feather as recommended by Dr. Peters—the work being done much more quickly and thoroughly with the former than the latter. The third day after the application of the remedy and the 12th of the disease, the patient showed signs of improvement. The low muttering delirium passed away, the swollen features assumed their more natural and human character, while the pustules showed signs of shrinking. There was no secondary fever, and at the end of the fifth day from date of application the pustules were literally shrivelled up, without giving out any of their fluid contents. In a word the disease was aborted.

The sulphide is evidently absorbed and acts in a constitutional manner, for the pustules on the parts of the body and arms not painted, shrivelled and dried up equally as rapid as those where the application was made.

Another important feature noticed, was the entire absence of itching and desire on the part of the patient to scratch. At no time did the patient feel any desire in that direction, and the sickly, deathly exhalations, so characteristic, were scarcely perceptible. An examination of the patient's face last week, revealed no pitting—a very important consideration. The blinds were not drawn nor the room darkened, but a flood of sun-light was permitted to enter the room, and the freest ventilation possible enjoyed. With the exception of slight ulceration of the cornea of the right eye and a slight attack of pleurisy of the right side, the patient made a rapid and successful recovery. The patient was kept on milk diet throughout, and only mild diuretics were employed as occasion required.

The liquid is prepared by boiling a quarter of a pound of quicklime and half a pound of sulphur in five imperial pints of water until the liquid is reduced to three pints, when it is filtered and kept in glass-stoppered bottles. It is applied to the affected parts two or three times a day with a brush or feather, taking care that none of it gets into the eyes.

The writer believes that the lotion acts by destroying the germs of the disease, preventing suppuration, and guarding against the complications that result from blood poisoning.

Reports of Societies.

ONTARIO MEDICAL ASSOCIATION.

The fifth annual meeting of the members of the above Association was held in London, on the 3rd and 4th ult., Dr. A. Worthington, of Clinton, President, in the chair, Dr. J. E. White, of Toronto, Secretary. The attendance was large and representative. Drs. Howe and Park, Buffalo, Drs. Jenks and Brodie, Detroit, and Dr. Stewart, Montreal, were present as delegates and invited guests.

After routine, several patients were presented for the consideration of the Association.

Dr. Pope, of Bothwell, showed a case of cerebro-spinal meningitis, in which some paralysis of the right leg, and anchylosis of the hip-joint, had followed. The President also showed a case of neuralgia of the tongue, apparently caused by carious teeth. Dr. Edwards also presented before the Association two interesting cases of myo-sclerosis, occuring in two brothers. All the cases were examined and discussed by the members present.

The President's address was next in order, and was listened to with marked attention. After thanking the Association for the honor conferred upon him, he referred to the opinion held by the

talented Sydenham, who wrote and practised from 1660 to 1680, that the six most fatal diseases prevailing in the city of London, were the plague, ague, dysentery, scurvy, child-birth, and small-pox. He was the first physician who originated the idea and carried the principle into practice, expressed in the phrase *vis medicatrix naturæ*, that this force in nature should be aided, nor thwarted. About the middle of the seventeenth century, or just before the time of Sydenham, the mortality of parturient women in London was about two per cent., including after consequences, while at the time these statistics were taken (1885) it was reduced to one-half per cent., and since the introduction of antiseptics into obstetric practice the mortality rate will probably be diminished to about one-fourth of one per cent. One death in every 400 may be an under-estimate of the mortality from child-birth and after consequences at the present time, but since obstetric practice has been based upon a belief in the germ theory results have been much better. He referred to the probable discoveries in scientific medicine, which they might expect to be greater in future than in the past. Ague was now almost entirely disappearing. Scurvy was likely to be little more than mentioned in the text-books of the future; and with reference to the small-pox, of which the learned and accomplished Dr. Mead, the first London physician of the day, wrote in 1747 as impossible to vanquish, vaccination was introduced in 1798, which had successfully battled with the disease. Referring to fever, the President said Boerhaave (1701 to 1731) held a theory of fever peculiarly his own, which was that the blood was the cause, the explanation being that the blood was in a thick, viscid condition, leading him to advise and insist on warm drinks being given during fevers, and that much danger was present if cold drinks were used. He (the speaker) could well remember when a child, some sixty years ago, his aunt begging for a drink of cold water, during an attack of what he presumed was typhoid fever, and was refused, the doctor saying it was dangerous to give it. To Boerhaave then must be ascribed the untold misery of thousands who have died, famished or starved, for cold water. Most unfortunately his theory has been handed down even to the present, and it might be questioned if the idea was yet obliterated from the minds of some of the profession. He then alluded to the use of cold water affusions in fevers by Currie, and stated that there was no question of their efficacy in scarlatina in every form. He also pointed out the fact that the use of the thermometer under the tongue and in the axilla was introduced half a century ago. In conclusion, he expressed a hope that the brief review of medical science one hundred years ago would be considered worthy of some thought, as indicating the progress which might be looked for in the next century.

There being none of the members of the Special Committee, appointed in 1884, to report on the communication from the Women's Christian Temperance Union, present, Dr. Fulton moved, seconded by Dr. Bray, that a special committee be appointed, consisting of Drs. Holmes, of Chatham; Rosebrugh, Hamilton, Geikie, Toronto; Brouse, Brockville, and the President, to bring in a report on the following morning, which was carried.

A motion expressive of condolence with Dr. Workman, in his recent bereavement, was passed, and a committee appointed to prepare a suitable memorial to be transmitted to him.

The report of the Committee on Ethics was laid over for another year.

A telegram from the Wisconsin Medical Society, in session in Milwaukee, sending greetings, was received with applause, and the Secretary was instructed to telegraph a reply expressing similar well-wishes. Dr. J. L. Bray, of Chatham, read a short paper on "Cæsarian Section," giving the history of a case in which Dr. Jenks, of Detroit, assisted him; the woman died. Dr. Jenks gave a graphic description of the operation, and stating in conclusion that he was opposed to craniotomy.

An interesting discussion on medicine was opened by Dr. Tye, of Chatham, who read an able paper on "Diphtheria." The paper and discussion will appear in the LANCET in due course, so that we shall not attempt to give any epitome.

Dr. Fraser, of Sarnia, next read a very interesting paper on "Continued Fevers."

In the evening session the Secretary read a communication from Dr. McLean, of Detroit, wishing the Society every success, and inviting the members to Port Huron at the annual session of the state medical association. The Secretary was requested to write, thanking Dr. McLean for his kind invitation.

The discussion in surgery was then opened by

Dr. Powell, of Edgar, who read an admirable paper on "Plaster Splints." The paper was discussed by the Association, after which followed an excellent paper on the "Blindness of Pregnancy," by Dr. Howe, of Buffalo, illustrated by diagrams thrown upon a screen. After a paper on "Placenta Prævia," by Dr. Edwards, of London, and another by Dr. Groves, of Fergus, on "Renal Calculi," the meeting adjourned.

On the second day, Dr. Temple, of Toronto, Chairman of the Committee on Obstetrics, opened a discussion upon "Intra-uterine Medication." Dr. Roswell Park, of Buffalo, followed with a volunteer paper on the "Surgical Sequelæ of Fevers. Many cases illustrating the various lesions coming under this head were placed for the first time on record. An important paper, written by Dr. Keen, of Philadelphia, was referred to, and much additional light thrown on a subject worthy of close observation.

At this stage it was found necessary to divide into sections in order to get the papers all before the Association. Dr. Graham, of Toronto, presided over that on Medicine, and Dr. Aikins, of the same city, over that on Surgery and Obstetrics.

Dr. Henderson, of Kingston, led off in the first section with a paper upon "Pulmonary Cavities." Drs. McDonald and Graham of Toronto, took part in the discussion, and the general opinion expressed was in the direction of sustaining the contentions of Koch, regarding the connection between bacilli and phthisis.

Dr. Duncan, of Thamesville, on "Warburg's Tincture," Dr. Ovens, of Arkona, on "Trifacial Neuralgia," and Dr. Arnott, of London, on "Diet in Disease," closed the work in this section by papers worthy of attention. A paper was also read on "Mitral Stenosis" during the afternoon by the Chairman, Dr. J. E. Graham, of Toronto.

In the Surgical and Obstetrical Section, papers were presented on "Hemorrhage after Abortion," by Dr. Murray, of Thorndale, and on "The Treatment of Abortion," by Dr. Adam Wright, of Toronto; one of characteristic vigor and originality by Dr. Harrison, of Selkirk, and one upon "Intestinal Obstruction" by Dr. Atherton, of Toronto.

Dr. Yeomans, of Mount Forest, was down for a paper on "Compound Fracture of the Patella," but unfortunately had to leave by an early train. Finally, the discussion on "Cocaine Hydrochlorate" was opened by Dr. Reeves, of Toronto, and taken part in by Drs. Howe, of Buffalo, and Palmer, of Toronto.

The Special Committee appointed to answer the questions submitted to the Association by the Ontario W. C. T. U. presented the following report, which was adopted:

Is the beverage use of alcoholic liquors, by persons in health, beneficial? A.—No.

Is alcoholic liquor, as obtained in common sale, necessary in medical prescriptions, if so, in what cases particularly? A.—No, except in cases of emergency.

What ought to be the attitude of the medical profession towards the sale of intoxicants? A.—The medical profession is opposed to the indiscriminate sale of alcoholic liquors.

The officers elected for next year, when the Association will meet in Toronto, were: Dr. Tye, President; Drs. Arnott, Temple, Hillary, and Henderson, Vice-Presidents; Dr. White, Secretary; Dr. Graham, Treasurer; Drs. Wright, Campbell, Ayelsworth, and Mitchell, Corresponding Secretaries.

ONTARIO MEDICAL COUNCIL.

The annual meeting of the Ontario Medical Council was held in Toronto on the 9th ult. and following days. The following newly elected members answered to their names:—Drs. D. Bergin, Cornwall; J. L. Bray, Chatham; H. E. Buchan, Toronto; J. H. Burns, Toronto; C. T. Campbell, London; J. G. Cranston, Arnprior; H. W. Day, Trenton; R. Douglas, Port Elgin; E. G. Edwards, London; A. G. Fenwick, London; F. Fowler, Kingston; W. B. Geikie, Toronto; W. T. Harris, Brantford; G. Henderson, Strathroy; G. E. Husband, Hamilton; G. Logan, Ottawa; V. H. Moore, Brockville; Orr, Maple; Philip, Brantford; J. W. Rosebrugh, Hamilton; Russell, Binbrook; Ruttan, Napanee; E. Vernon, Hamilton; J. A. Williams, Ingersoll, H. H. Wright, Toronto, and J. A. Grant, Ottawa.

Dr Bergin was elected President, and Dr Douglas Vice-President of the College. Dr. W. T. Aikins was appointed Treasurer, and Dr. Pyne reappointed Registrar.

The standing committees were appointed as follows:—

Registration—Drs. Rosebrugh, Vernon, Fenwick, and Russell.

Rules and Regulations—Drs. Day, Burns, Fowler, and Williams.

Finance—Drs. Edwards, Henderson, Douglas, Philip and Ruttan.

Printing—Drs. Vernon, Burns, Buchan, and H. H. Wright.

Education—Drs. Fowler, Geikie, Moore, H. H. Wright, Edwards, Harris, Day, Husband, Logan, Williams, Burns, Cranston, Bray, Fenwick and Buchan.

Executive—Drs. Day, and Logan.

The report of the Building Committee stated that there was a suitable site for a new college south of the School of Practical Science on College-street, and recommended that a committee be appointed to secure the site. The site which belongs to the Toronto University, can be obtained, on payment of $500 interest on it annually to the University. The matter was referred to the Finance Committee.

June 10th 1885.

The Council met at 10 a.m.

Dr. Wright moved that all medical students engaged in the North-West, be allowed their full time, but they shall be required to take their primary examination next spring, or at the final examination.

Dr. Geikie moved in amendment, seconded by Dr. Moore, "That those primary students who had been prevented from undergoing the spring examinations by their service in the North-West, and who had paid their fees, be given their standing."

Dr. Wright argued that the Act gave no power to dispense with the examination, and the President on being appealed to for his ruling, suggested that both resolutions be withdrawn till the advice of the solicitor be obtained.

Dr. Day presented the report of the Legislative Committee. It stated that the Committee had been unable to obtain from the Legislature the amendments to the Medical Act, which were deemed so necessary, but had hopes of obtaining legislation next session. They therefore recommended the re-appointment of the Committee.

An application was received from Dr. E. B. Sparham, of Brockville, asking that his name be reinstated in the list of those licensed by the college to practice.

June 11th, 1885.

The Council met at 10.30 a.m.,

Dr. Fenwick moved that the Council examinations be held in London, as well as Toronto and Kingston. The matter was referred to the Committee on Rules and Regulations.

Dr. Cranston moved that the President, or in his absence, one of the officers of the college, shall have power to appoint in each territorial division, on the recommendation of the representative for such division, one or more persons whose duty it shall be to prosecute persons practising in contravention of the Medical Act, and that the prosecutor receive 75 per cent. of the fines inflicted. Carried.

A by-law was then passed fixing the annual assessment at $1 per annum.

A by-law was also introduced by Dr. Williams, and passed, fixing the date of the professional examinations on the first Tuesday in April in each year.

Dr. Campbell moved that a copy of the proceedings of Council be printed and forwarded to each member of the college.

Dr. Wright moved in amendmenr that a synopsis of the proceedings be printed in the annual announcement, and a copy sent to every member in good standing. The amendment was carried.

Mr. Dalton McCarthy, Q.C., the solicitor of the Council, gave as his opinion that there was nothing in the Medical Act to prevent the Council from giving students in the North-West their primary examinations. Dr. Geikie then introduced a by-law to the effect that the students be allowed their primary examinations, which was carried.

The following were appointed members of the Legislative Committee: Drs. Day, Cranston, Edwards, Fowler, Williams, Husband, Douglas, Logan, Moore, Wright, Geikie, and Harris.

The members of the Council were entertained at lunch, in the evening, by Dr. Aikins, Jarvis St., in which they were joined by members of the profession in Toronto, and a pleasant time was spent.

June 12th, 1885.

The Council met at 10 a.m., the Vice-President in the chair.

Dr. Bray moved that the Legislative Committee be authorized to approach the Legislature next session with the object of obtaining the desired amendments to the Medical Act.

On the report of the commitee appointed to recommend a solicitor for the council, Mr. B. B. Osler received the appointment.

The Registration Committee reported in favour of allowing F. B. McCormick, South Point, Pelee Island, to come up for registration. They also reported that the Council had no power to re-enter the name of E. B. Sparham on the register.

The opinion having been expressed by the solicitor that the University of Ottawa had no power to confer degrees in medicine, and therefore no right to representation in the Council, a reply was received from the authorities of that institution stating that they had the power to grant degrees in medicine. Dr. Grant, of Ottawa, who was present, was accordingly invited to take his seat as repretative of the Ottawa University, and accepted the invitation amid great applause.

Dr. Cranston moved that a vote of thanks be passed to the Ontario Government for their exertions in perfecting the Bureau of Health. Carried.

Dr. Wright presented the report of the Education Committee, which was adopted. It recommended a change in the regulation requiring graduates of arts to spend four years in college, to three years as formerly; also that students passing the matriculation examination, shall prove their identity. It also recommended the increase of the registration fee to $25, and the re-appointment of the examining board of last year.

Dr. Day presented the report of the Committee on Rules and Regulations. It stated that the solicitor had reported that the Council had no power to hold its final examination except at Toronto and Kingston, but that primary examinations could be held wherever the Council chose.

Dr. Henderson presented the report of the Finance Committee, which was adopted. It stated that there was a balance on hand of $6,291.53, after all expenses had been met. The total assets, including cash on hand, building and grounds, and dues uncollected, are $33,291.51, and total liabilities embracing the mortgage and interest, expenses of the present Council, and unpaid accounts, $8,318.39. There is a balance in favor of the Council of $24,973.14. The arrears of members' fees amounted to $7.000.

Dr. Grant moved that Drs. Burns, Wright, and the Secretary, be a committee to adopt some inexpensive way of protecting the papers and documents of the Council. Carried.

Dr. Harris moved that this Council record with pleasure its sense of the zeal displayed by those medical students who have served in the North-West. Carried.

After the passing of formal votes of thanks the Council adjourned *sine die.*

Selected Articles.

DISSEMINATED CEREBRO-SPINAL SCLEROSIS.

BY DYCE DUCKWORTH, M.D, F.R.C.P.
St. Bartholomew's Hospital.

GENTLEMEN,—I bring before you to-day a patient lately admitted to Bed 1, in John ward, whose case furnishes me with some points of great interest, to which I shall ask your attention. It is one of a class well fitted for a clinical lecture, which, as you know, is nothing if not demonstrative, and little more than a systematic or didactic one if the patient is not brought before you. Clinical medicine has all to do with individual cases, and that teaching of it is most proper which best illustrates the points to be noted to each of you in as direct and living a manner as possible.

I will presently tell this man to walk across the theatre, and ask you to notice his gait. If you look at him first as he stands at rest, you will not observe anything remarkable about him. You see a young man in seeming good health, well nourished, and with complete control over his equilibrium. I now ask him to close his eyes. He stands erect, and without any tremor or instability. And now, as he walks, you notice a peculiarity in the action of his right leg. This limb moves stiffly, and there is over-action of it. It is lifted higher off the ground than the other, and is clumsy in movement. We say there is some spastic action in it. I now give him this glass of water to take in his right hand. At once, you see, a violent spasmodic action occurs, vigorous tremulation, so great that he nearly empties all the water before he has well seized the glass. If he next attempts to raise the vessel to his lips, the movements become more and more exaggerated, so that all the water is spilt and the empty glass rattles against his teeth. I remove the vessel from his hand, and all the spasm ceases forthwith. As he stands quietly once more, you notice that the right arm remains tranquil and free from tremor. I try his power of grasp in each hand, and find a marked weakness in the right one, although he is a right-handed man. I now lay bare his forearms and compare the condition of his muscles. You observe no signs of wasting; the muscles are well developed and of good and equal tone on both sides. On examining his face, you see that his muscles of expression are stable and free from tremor, his lips firm, and his eye-balls quite steady. His pupils are unequal, certainly, but that is due to the action of atropine in one of them, used to allow examination of the retina of the right eye. No squint; no facial palsy. Testing his sensory functions, we find no abnormal state; all is as it should be. On enquiry as to any

subjective sensorial sensation, he assures us all is natural in each of the four extremities. To curtail our further examination, I may add that there is nothing more to be detected by any physical methods we can employ, save that the knee-reflexes are exaggerated, markedly on the right side, while no ankle-clonus can be elicited. We have, then, a seemingly healthy and vigorous young man, whose only troubles are a clumsy limping gait, due to disorderly action of his right leg, and inability to employ his right hand and arm because of powerful tremulation and disorderly spasm, which come on the instant he directs his will into this extremity; and this is all. Before he leaves the theatre I ask him to repeat a sentence after me. You notice that he speaks clearly and fluently—with a good Wiltshire accent to be sure, but without any hesitation or difficulty; and yet, again, on protruding his tongue, you find no noteworthy tremor or peculiarity in it. Let us now take up the history of this case; it is very brief.

G. R.——, aged twenty-one, a groom, was sent up to us by a former pupil of the hospital, and admitted on Feb. 14. He states that nine months ago trembling movements began in his right arm, which prevented him from following his occupation.

Later on the right leg became affected, so that he could not walk far on account of the weakness in it. Inquiry into his past history revealed no important illness. He had never had rheumatism, and there was no known history of this or of gout in his family. He had never had chorea, although his present ailment was at first believed to be of this nature. There was no neurotic history in his family, no indication of any previous paralytic attack or hemiplegia, no injury of any kind, and no history of fits. His duties entailed exposure to all kinds of weather, but to no extraordinary exposure. Previous to admission, he had been treated, we learned, with arsenic, belladonna, mineral water bathing at Bath, &c., all without avail.

You have already noted that the patient appears a healthy and well-nourished man, and that so long as he makes no voluntary efforts with the limbs of the right side of his body there is no indication of disease about him. I show you a specimen of his attempt to write his name. After violent efforts to control the right hand he made this unintelligible series of scrawls. With the left hand he has learned to write fairly legibly, but slowly and with difficulty, still without any spasm or tremor. He is awkward in setting his right forefinger on any point; thus he makes bad shots at his nose when he tries to touch the end of it, and hardly succeeds in getting near it. Dr. Stevenson has given us a report on the electrical reactions of the muscles of the affected limbs, and he states that they all react normally to both continuous and interrupted currents, and that there is no loss of electro-sensibility. We have seen the exaggerated reflexes at the knees, especially on the affected side; and you may note an increase in the supinator-reflex of the right arm. No fibrillary muscular contractions. On examining the thorax, nothing abnormal is found. The heart-sounds are healthy and sufficiently loud. The urine is natural and the sphincters act perfectly. Special senses not perverted. No vertigo. Knows where his feet and hands are. Retinæ perfectly healthy, and optic discs well-defined. No nystagmus; pupils react naturally; no strabismus. No history of syphilis, and no signs of either inherited or acquired disease of this character. No tenderness on percussing the cranium at any point. In trying to follow with his right toes a circle drawn on the floor is he very clumsy and erratic. He can jump, though with exertion of more force than is necessary for the distance traversed. The difficulty with the right leg is best seen when he tries to run.

We find, on the whole, more negative than positive signs in this man, and yet we have very definite symptoms before us. What is the lesion here, and where is it? What is the diagnosis and what the prognosis, and the best treatment of it? I mentioned that chorea had been at first suspected in the case. Chorea is sometimes one-sided, and often so, for a time in many instances. You would not or you should not long be mistaken as to this. You know that choreic movements are incessant except during sleep, and not only elicited by effort, although they are aggravated by voluntary efforts. And you would not expect to meet with a case of one-sided chorea lasting continuously for nine months. We may, therefore, put that aside. You think, perhaps, of another nervous disorder characterized by tremors and paralysis agitans; the shaking palsy (Parkinson's disease) suggests itself to you. Is this the malady before us? Here is Parkinson's own definition, written in 1817: observe if it tallies with our case: "Involuntary tremulous motion with lessened muscular power in parts not in action, and even when supported; with a propensity to bend the trunk forwards and to pass from a walking to a running pace, the senses and intellect being uninjured." This definition will not apply here. The rule is for the tremor to be persistent and constant in shaking palsy, and rather to cease or moderate when action is induced. The contrary is the case here. Action at once induces tremor. The age of this patient is against his being the subject of shaking palsy, this disorder being very rare before forty years of age are reached. Have we here to deal with a case of so-called post-hemiplegic chorea? I think not, because we have no history and no signs of a past attack of hemiplegia, and the characters of this man's tremors are not those of the disorder I have alluded to. To mention mercurial tremors is sufficient. These are symmetrical, and affect the head, and the signs of mercurialism are always obvious. We can also exclude hysterical tremors and malingering.

We are brought, at last, to consider this case, then, as one of a class known as insular or disseminated cerebro-spinal sclerosis, or Charcot's disease, as it has been called. It is a remarkable example, certainly, because the disorder is, at present—note, I say, *at present,—hemiplegic in character, and also manifestly in an early stage.* We do not often see such cases. This is our diagnosis: sclerotic patches situated in the left half of the brain, possibly in the corpus striatum or crus, and possibly in some portion of the medulla spinalis. I should not like to pronounce with greater certainty anything more than this at present, though I might exclude the inferior frontal convolution and parts around the fissure of Sylvius, with some other regions. We may exclude scrofulous and syphilitic disease in the case, and we are in face of the characteristic lesions which are usually found in these cases, and for which I refer you to your studies in morbid histology. The age of our patient is just that at which this malady declares itself. It is equally common in each sex, and very rare after forty. Exposure to cold has been a commonly assigned cause. In this disease no muscular *wasting* occurs, although loss of muscular *power* is found, and no electrical changes arise. Paresis precedes the tremors, and the reverse is the case in shaking palsy. The reflexes are exaggerated. I should not omit to point out to you that many symptoms are wanting in this patient to complete the picture of a typical case. Such a one we had fifteen months ago in John ward. For example, one looks for nystagmus, and for certain symptoms referable to disorder in the medulla oblongata in most of these cases. I never met before with the exact conditions you see in this man; but, still, I have hardly any hesitation in making my diagnosis.

As to prognosis. This is certainly grave. I surmise that we have so far only early symptoms before us, and that the disease will make sad progress in time. We may fear the onset of paresis and tremors in the sound limbs, and the implication of speech with what are termed bulbar symptoms. The sclerotic process may spread and new patches of it occur in other portions of the cerebro-spinal system, thus setting up new symptoms. The course of the malady is slow, and may occupy from five to ten years. Deceptive periods of improvement may occur from time to time. Too often the disease goes on from bad to worse till the patient is rendered helpless and bedridden, the limbs becoming rigid and paralytic dementia supervening. Can we do nothing to arrest this terrible process? Must it go on to the bitter end? Alas, the resources of our art are, we must honestly avow, powerless as yet to avert the progress of this terrible malady. Physicians have been very assiduous in elaborating the differential diagnosis of nervous diseases of late years, but in respect to therapeutics we have as yet scored few triumphs. The outlook is bad, and we might almost despair of rendering help. We shall never do this, I hope, but rather strive the harder to find means of arresting this untoward process. No one drug is pre-eminently indicated. I am giving this man mercury, and mean to bring him fully under its influence. He takes three grains of blue pill each night. Not that I am trying to eradicate any syphilitic taint, for, in truth, we know of none in this case. But we know that mercury is a powerful drug, and able to modify nutritional force very materially. We shall do our patient no harm with it. It may be that some of these obscure perversions of growth are evolutional forms of syphilis transmitted from infected ancestry, and so mercury, fully tried, may chance to be of special use. We know, at any rate, that in the peculiar form of systematic sclerosis of the posterior spinal columns known as the tabes dorsalis—locomotor ataxia—syphilis plays a very prominent part, to the extent, indeed, of eighty per cent., or more, of all cases. Not that the lesion is itself directly syphilitic or gummatous, but that syphilis, as syphilis, seems to predispose to the particular form of sclerotic change in the cord which sets up the disease we know as tabes dorsalis. We are also maintaining the nutrition of this man's nervous system by cod-liver oil and a good diet. Nitrate of silver has been found of use in early stages of this disease. But for some time to come I should prefer to use mercury and iodide of potassium and carefully watch their effects, and I shall bring the results and the further history of this remarkable case before you on a subsequent occasion.—*Lancet.*

THE "HAMMOCK" MODE OF APPLYING THE PLASTER JACKET.

Dr. A. B. Hirsh, of Philadelphia, gives the following, in the *Med. & Surg. Reporter:*

What physician who has ever treated spinal deformities has not lost temper when using ordinary *suspension* to apply the plaster jacket, when the patient has almost been strangled by a sudden slipping of the straps sustaining the head, or has fainted or become utterly unmanageable? Then, too, there is the discomfort to the patient of keeping up a constant muscular strain, in a peculiar position, for a more or less lengthened period; while if (as usual) he or she be young in years, the fear or even fright of the patient adds to the unpleasantness of the whole affair. Of course, the expense of the necessary tripod and accompanying apparatus is also not the least item to the practitioner.

These thoughts were suggested by seeing Professor Nancrede recently apply a plaster jacket at St. Christopher's Hospital, before his polyclinic class. No originality is, I believe, claimed—an English surgeon first having suggested the ham

mock for this purpose. In this case, a poorly-nourished Irish lad, aged some eight years, had the corset applied for a posterior dorso-lumbar curvature, although the doctor explained that any and every variety of spinal deformity could be treated by a modification of the same method.

A piece of ordinary "ten-ounce burlap"—the bagging used to wrap around rolls of carpet, etc.—some seven feet in length and three feet in width, was suspended between the two sides of the room. Each end of the canvas has a "casing" about one and one-half inches wide, strongly sewn, and a rope drawn through the space thus made (so as to "bunch" the end), which is then attached to a heavy hook or ring screwed into the wall, with a compound pulley and rope to render taut the swing; here we have the convenient hammock as required.

The lad, devoid of clothes, except a woolen undervest, was next placed therein, face downwards and with hands and feet extended—the former grasping the sides of the hammock, so as to exercise some extension—and a hole was cut through the bottom of the swing opposite to the nose and mouth, so as to allow him to breathe easily. Care was taken to fit the usual abdominal pad, and to keep the hammock well balanced. The hammock was then cut transversely on a level and down to the iliac crests; the same was done at the upper margins of each axilla. The flaps thus formed were folded around the body, the surplus portion removed, and the whole roughly sewn up, thus forming a second undervest around the woolen one. Starting from above, the bandage was now carried around the body until the deformity was completely covered, the canvas being, of course, included in the turns. The plaster was allowed to set, and the patient relieved from his swing by cutting loose the burlap above and below the jacket, and the procedure was complete. At no time was discomfort complained of, as the little one even joked about the novelty of his situation.

The professor proceeded to explain that this hammock achieved all the good that Sayre's swing did, and obviated all its objectionable features. On the latter, the curves above and below the gibbosity were straightened out, as well as any lateral deviation, and thus the apparent increase in height was obtained, while the weight of the body, by a true process of leverage, effected through the over curved portions of the spine, above and below, theoretically tended to separate the softened and diseased anterior surfaces of the vertebral bodies. Whether this latter result was desirable, if obtainable to a marked degree, was more than doubtful in the lecturer's mind, as he thought all that should be aimed at was to remove the weight of the trunk, head, and upper extremities—one or all, according to the portion of the diseased vertebræ—and to place the column in the best position attainable, for anchylosis and future usefulness. In the same way, the prone position in the hammock effaced the curves, and, by leverage, tended to separate the anterior surfaces of the vertebral bodies. The degree to which the hammock was allowed to "sag" would determine the amount of extension exerted upon the spine.

This method was cheap, comfortable and always available, without any special apparatus, beyond bagging, ropes, and strong screw hooks, staples, or some similar contrivance. The patient might be allowed to swing for hours, until the plaster was perfectly dry, thus obviating the risk of cracking the jacket, which sometimes happens when the patient is perforce, taken down too soon from Sayre's swing, on account of fainting, etc., as the professor had experienced in his own practice. The screaming, struggling, and terror, so common with children, is all done away with. It is the part of wisdom to place a mattress on the floor beneath the hammock, lest any part of the apparatus break, and a serious fall result. The professor now always resorted to this method of applying the jacket, and was perfectly satisfied with it.

INTERNAL SPINA-BIFIDA.

Dr. Thomas was consulted by a married lady, aged twenty-eight, two years married, but sterile. She complained of nothing but pain in sacral region, and sense of weight. On examination he found a sac filled with fluid, occupying the cavity of the sacrum, and pushing the rectum aside slightly, but in no way occasioning serious inconvenience. He believed the failure to conceive was due, not to the pressure of this tumor, but to a congenital sharp anteflexion, and advised non-interference. The case stumped the doctor—he didn't know what to make of it—though he examined the case repeatedly, at intervals, for two years, when he lost sight of it. Some time afterwards he was consulted by a beautiful girl, nineteen years of age, who appeared to be perfectly healthy, but who suffered from dysmenorrhœa. She was engaged to be married, and she and her mother were anxious to have any impediment removed that might be in the way, and hence the consultation. Dr. Thomas found a sac filled with fluid, situated in the curvature of the sacrum, and impinging on the vaginal canal to such extent as to almost completely occlude it, and this, the doctor thought, was the cause of her dysmenorrhœa. He strongly advised non-interference, stating that in view of the obscurity of the case radical measures were not justified. Mother and daughter insisted, and finally the doctor consented to a compromise—he would aspirate the sac. He did so with the smallest-sized Dieulafoy's needle, drawing off eight ounces of perfectly limpid non-albuminous fluid, which was submitted to Dr. Garrigues for examination. Dr. G. declined to

give an opinion of the nature or source of the fluid. The effects of this operation were alarming; the girl was thrown into violent fever with headache, which lasted several days. This was attributed to the "thief in the community," malaria, and treated with quinine and morphia hypodermically. Some six months afterwards, the patient and her mother called again: the sac had refilled, and they renewed their importunities for an operation. Dr. Thomas was strongly impressed with the impropriety of any operation, especially in view of what had just been related, and was possessed, he says, of a strange feeling of dread and fear. However, he yielded. He would open the sac, and establish drainage. With proper assistance, patient in lithotomy position and anæsthetized, Dr. Thomas made an incision into the sac and stitched the edges to the vaginal opening. There was discharged about half a pint of the same clear fluid, resembling hysterical urine. In five hours, at 8 p.m., she was seen by Dr. Dubois, one of the assistants; severe headache and marked tendency to hysteria. In the morning, headache more severe, pulse 110, temperature 102. In the evening, symptoms same, with a peculiarly wild and and maniacal expression. Still the doctor did not suspect the real nature of the case. Next morning all symptoms were favorable, but in the afternoon the physician was summoned in haste to see her. Found her in a condition bordering on hysterical mania, with pulse 120, and temperature 104, with strong tendency to opisthotonos, and showing marked signs of incipient tetanus. "Now," says the doctor, "there suddenly flashed across my mind the full recognition of the case; an exactly similar one, which had occured to Dr. Emmet in the Women's Hospital, came back to my memory, from which, until now, it had been entirely effaced; and, as if a curtain had been lifted, I saw clearly what had, until this moment, been so obscure. I had opened a sac formed by the meninges of the cord, which had projected through an imperfection in the sacrum, into the pelvic cavity. The membranes of brain and cord were deprived of the rachidian fluid, and the consequences were before me! I at once collected my assistants, and anæsthetized the patient with chloroform, and sewed up the opening in the sac. * * * Whether from chloroform narcosis or not I cannot say, but for some hours after this, the patient markedly improved, and I had great hopes that I had retraced my unfortunate steps in time; but about twelve hours after the closure of the sac the heart suddenly failed, opisthotonos occured, the patient shrieked from severity of her cephalalgia—and died!"

In the conclusion of this most interesting record, Dr. Thomas says:

"Where a cyst is found in the pelvis, behind the rectum, filling the hollow of the sacrum, apparently attached to that bone, let the diagnostician carefully exclude the possibility of its being spina-bifida before interfering with it."

2. "If it be decided to interfere with such a tumor, let a small portion of the fluid be first drawn by a hypodermic needle, and if this be found to be a limpid, non-albuminous fluid, let the probabilities of the sac being connected with the meninges of the cord receive due consideration, and guard against further interference.—*Am. Med. Digest.*

HYSTERECTOMY FOR UTERINE FIBROIDS.

Dr. W. T. Lusk presented a large fibroid tumor *(N. Y. Obstet. Society)*, together with a number of smaller ones, which had been removed, with the uterus, from a patient who gave the following history: She was thirty-eight years of age, and entered the hospital in March last, suffering from ascites and some form of abdominal tumor. The ascites was so great that it was impossible to determine the exact nature of the tumor. The patient was greatly reduced in flesh and in general health, and was passing only from one to five ounces of urine daily. It seemed hardly possible that she could live more than a few weeks. Dr. Lusk removed a portion of the ascitic fluid, after which he was able to make out what he supposed to be a large fibroid of the uterus, although he was in some doubt whether the case might not be one of abdominal pregnancy. After the patient had been under observation for some time he became convinced that it was one of multiple fibroids of the uterus, there being one large tumor and a number of smaller ones attached by pedicles. Mr. Tait, who had been asked to examine the patient, had summarly rejected the idea of uterine fibroma, and, when asked what he thought the condition was, had characteristically replied, "Cut the patient open and find out." Several other gentlemen, however, who saw the patient a day or two later, coincided in Dr. Lusk's diagnosis. Dr. Lusk was surprised, on returning from the country after the summer, to learn that the patient was still alive, and had even improved somewhat in condition. The house physician had been giving her acetate of potassium and digitalis, and so long as these medicines were continued the urine was secreted in normal quantity, but as soon as they were withdrawn it decreased in amount and her condition grew worse. Her desire to go home was acceded to soon after Dr. Lusk's return to the city, but she had scarcely been absent twenty-four hours when the dropsy largely increased in amount, and she returned and was again given acetate of potassium and digitalis, with the effect of increasing the urinary secretion. The urine contained albumen. It was evident that the patient could not live much

longer without interference, and yet the kidney complication and ascites made recovery after an operation extremely doubtful. It was decided, however, to make an abdominal section, Dr. Lusk's idea being that if only a single fibroid was removed it would tend to make the patient relatively comfortable. The operation was performed about seven weeks ago. When the peritonæum was opened, about a gallon of ascitic fluid escaped. It was the operator's intention to remove the fibroids one after another, but they proved to be very numerous, and, accordingly, he turned out the entire mass, threw a powerful, large-sized rubber cord around its pedicle and cut it away.

The only point to which he wished to call special attention regarding the operation was the fact that, after the method of most operators in such cases, he introduced the needle, intended to fasten the pedicle to the abdominal walls, through the stump below the ligature. This he now regarded as a mistake, and, on account of the distress which it caused the patient, he withdrew the needle on the third day and passed it through the stump above the ligature, which afforded some relief. The day following the removal of the needle some febrile disturbance developed, which was found, on lifting the stump with a tenaculum, to be due to a collection of about a teaspoonful of pus in the upper portion of the wound. The next day the temperature rose again, and it was then found that there was some pus in the lower portion of the wound. As soon as this fœtid pus was washed away the temperature fell, and convalescence was thenceforward uninterrupted. There was no further kidney trouble after the operation; the urine was secreted in normal quantity, and no longer contained albumen. This fact was worthy of note, because it was stated in works on obstetrics that inefficient action of the kidneys in puerperal eclampsia was not due to pressure of the gravid uterus, otherwise a like trouble would arise from pressure of ovarian and fibroid tumors. Here was a case in which pressure was made by a tumor, and removal of this caused albumen to disappear from the urine immediately, and the fluid to become secreted in normal quantity. In reply to a question, Dr. Lusk said the entire uterus was removed with the tumor, which weighed seven pounds and a half; the stump separated on the twelfth day. He had had the valuable assistance of the president during the operation.

The President asked Dr. Lusk, who had spoken of tympanites (which was present in this case) as being the rule, if this was true of all cases of extirpation of the uterus, whether the stump was treated extra-peritoneally or not. Dr. Lusk said he meant to refer only to those cases in which, the stump being short, the pressure of the needle was very near the descending colon.

Dr. J. B. Hunter remarked, with regard to the effect upon the kidney of removal of the tumor, that recently, in two cases operated upon by two different surgeons in this city, the urine, which had been apparently normal, became completely suppressed about the seventh day after the operation, and the patients died. The cases had progressed favorably until suppression of the urine had taken place. Dr. Hunter also remarked that he had employed the rubber cord, shown by Dr. Lusk, with satisfaction.

The President had reported a case last spring in which he hesitated to operate for the removal of a fibroid tumor, because the urine contained albumen, but, instead of suppression of urine after the operation, as had been feared, the albumen disappeared and the secretion became normal, showing clearly that albuminuria had been due to pressure of the tumor upon the kidneys or upon the ureters.—*N. Y. Med Journal.*

MOTOR APHASIA FROM INJURY, WITHOUT PARALYSIS OF ANY OF THE LIMBS.

Dr. J. H. Burns reported the following case to the Toronto Medical Society *(Med. News)*. Mr. K., æt. 56, healthy and robust, fell down stairs; he was assisted to his feet and with help walked to a chair. He did not then speak or at any time subsequently. He became unconscious about three hours later. In my absence Dr. Duncan saw him that evening for me, and with me the next morning, by which time he had recovered consciousness and was able to leave the bed. His bowels had been freely moved with croton oil. There was an injury to the soft tissues over the right eye, but no fracture could be made out. He swallowed with great difficulty; there was neither motor paralysis nor anæsthesia of any part of the limbs. Twenty-four hours after injury pulse was 100, temp. 101°. Dr. Workman saw him in consultation following morning; temp. 104°, pulse 120. During the afternoon he had a convulsion and after that convulsions recurred every ten minutes till he died at 2 p.m. next day. The left side was most affected with the convulsions. During this time there was retention of urine. Death took place sixty-eight hours after injury.

Post-mortem seven hours after death. Extravasation into subcutaneous tissue over parietal and temporal bones of right side. There was an extensive fracture in this region, with slight depression. Dura mater intimately adherent to calvarium. A large clot was found between dura mater and skull at seat of fracture. Great congestion of cerebrum beneath this. Another clot was found beneath the dura mater on left side of brain opposite seat of injury, with extensive disorganization of the lower part of middle lobe of brain on left side. Heart

and lungs normal, liver small but apparently healthy, kidneys healthy.

Dr. Duncan, who assisted at the autopsy, said there were two distinct clots on the left side; one in the arachnoid space pressing on the temporo-sphenoidal lobe, another beneath this in the brain substance, in which on removal of the clot there was a laceration half an inch deep and one and one-half by one and one-fourth inches in extent. This clot probably resulted from rupture of a branch of the Sylvian artery. From symptoms, he had expected to find some such injury. The presence of *three* distinct clots was an unusual circumstance.

Dr. Workman said that he visited the patient in consultation on the 13th of April, and he is able to confirm all that has been stated. The symptoms that most attracted his attention was that of motor-aphasia unaccompanied by any paralysis in the lower or upper limbs. The only mark of external injury was the swollen and blackened state of the right eye. Close examination of the supra-orbital region of the frontal bone gave no indication of fracture, nor did examination of the side of the cranium present any. The patient had evidently free use of the muscles of the arms and legs. When he saw him there was no stertorous breathing, neither was pronounced coma present, but there was a certain degree of torpor or somnolence, which he apprehended would culminate in coma. He had not spoken from the time of occurrence of the injury, neither had he taken any drink or food, most probably because of the paralyzed state of the glosso labial muscles. The large extravasation of blood in the left temporal region, the result of the *contre-coup*, showed that some important vessel, most probably a branch of the Sylvian artery, had been lacerated, and it would appear from Dr. Duncan's statement that the cerebral substance in the Sylvian region was greatly injured. He had no doubt that this part coincided with the foot of the ascending frontal and the posterior part of the third frontal convolution, in which are the motor-centres for the speech muscles and for those of deglutition, etc. The absence of any mark of injury in the vicinity of the fissure of Rolando, accounts for the persistence of muscular power in the arms and legs. He regarded the case as one of much interest, in confirmation of the now so universally admitted doctrine of cerebral localizations.

TREATMENT OF INFECTIOUS SORE THROAT.

I always administer an emetic in the beginning. As long as vomiting lasts and the tongue appears coated, I give as little nourishment as possible. All my patients were young and vigorous, so that, instead of stimulating, I had more than once the idea of bleeding, and would have done so, on account of the active inflammation, had not the feeling of general debility which attends these cases restrained me. This period usually continues to the third day, when, the irritability of the stomach having ceased, I let them take fluid but nutritious food, returning to solid aliment as soon as the condition of the pharynx permits its being swallowed without injury to the inflamed parts. I further advise the patient to use the following gargle every ten or fifteen minutes:

℞—Acid salicylic,	ʒ j.
Acid carbolic,	♏ xxiv.
Sodii borat.,	gr. lxx.
Glycerine,	f ʒ j.
Aqua distillat,	f ʒ xj.—M.

Sig.—Use as a gargle.

Internally I order a teaspoonful, in half a tumblerful of water, of this medicine:

℞—Quinine hydrochlorat,	gr. xxxvj.
Tinct. ferri chlorid.,	f ʒ j.
Acid muriat. dilut.,	f ʒ ij.
Tinct. cardamom comp.,	
Glycerine,	
Syr. aurant. cortic., *aa* q.s. ad.,	f ʒ iij.—M.

This is taken every three or four hours until the more moist appearance of the tongue and the general condition of the patient indicate amelioration of the symptoms, when the size and the frequency of the doses are rapidly diminished. As soon as the first indication of disturbance of the urinary function sets in, I prescribe a teaspoonful of infusion of digitalis, to be taken every four hours. When the secretion has been re-established, I still continue for one week longer the same dose; for another day the patient is directed to take it but three times daily, and then this medicine is stopped, having achieved its purpose. If the pain in the neck or in the shoulder be very severe, I have found the best result from this liniment:

℞—Chloral hydrat.,	ʒ j.
Camphoræ,	ʒ ss.
Ol. amygdal,	f ʒ j.—M.

Sig.—To be applied with a camel's hair brush to the painful parts, the application to be renewed on return of pain.

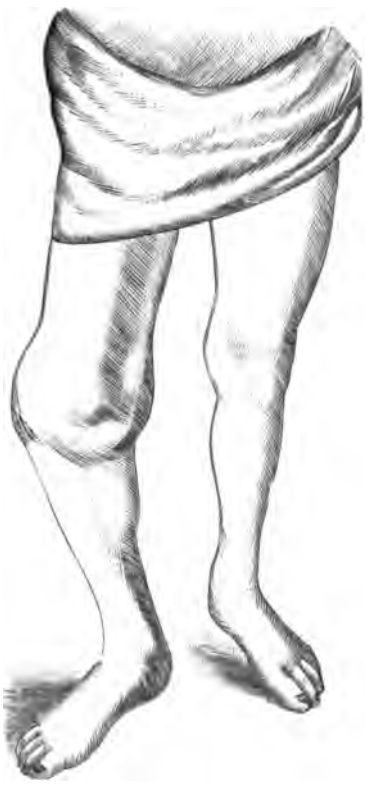
Besides paying attention to the bowels and employing general measures, as regular feeding, cooling drinks, sponging of the body several times daily, etc., the above contains the whole treatment. For the sleeplessness commonly met with in the beginning I have ceased to prescribe, as experience has taught me that the patients feel better, regain sooner their natural sleep, and recover more quickly, when no hypnotic whatever is employed.—*Hugo Engel, M.D., in Phil. Med. Times.*

CHARCOT'S JOINT DISEASE.

[Dr. A. Sydney Roberts, of Philadelphia, gives a report of six cases of Charcot's joint disease in the *Med. News*, Feb. 14, 1885, from which we select the following case (iv), with illustration.] ED.

Dr. A. A. Y., male, æt. 65, resident of Hammonton, N. J. Examined the patient with Dr. S. Weir Mitchell on January 16, 1885. For the substance of the following notes I am indebted to Dr. Woodnutt.

Hereditary history of patient excellent. He had always been strong and healthy during youth, and up to 1865, though a hard-working farmer. An army life, and three years of extreme exposure prior to the close of the war, found him suffering in 1865 from sharp, wandering pains in the upper and lower extremities; never noticed, however, in



the articulations. Loss of power followed in the right leg. Three years later suppurative arthritis attacked the metatarso-phalangeal articulation of the right great toe, and last phalanx of left ring finger, sequestra coming away in each instance.

During 1870 the patient first noticed an œdematous swelling of the right elbow; following shortly upon this, the wrist joint of the same arm gradually and painlessly enlarged. Then a distension of the capsule of the right knee-joint succeeded. The enlargement of the latter articulation was more rapid than either the wrist or elbow. Rheumatic pains in the joints accompanied the swelling and deformity.

The left limb has been comparatively exempt from pain. Recently, however, the capsule of the knee-joint has become distended and elastic. The elbow tumor has diminished somewhat in circumference during the past four years.

During the past year the distal phalanx of the right index finger has gradually atrophied, without inflammation, and is entirely wanting. The nail and finger end are normal, though somewhat shortened. Pain, at present, is chiefly in both feet, paroxysmal and erratic, often attacking corresponding points on the legs.

The present appearance of the right elbow and knee joint enlargements exhibit an irregular nodulated hypertrophy, bearing no resemblance to normal joint outline, and consisting chiefly of osteophytes and abnormal increase of synovial fluid. Motion preternaturally free in all directions; structure of joints apparently entirely destroyed.

Remarks.—The joint lesions first appeared in this patient after ataxia had become established. The appearance of the affected elbow and knee is that of an enormous nodular hypertrophied mass of bone, doubling their normal circumference, associated with synovial distension of the capsule. Osteophytes readily movable with the capsule, and varying in size from a pigeon's egg to that of a turkey.

The atrophy of the distal phalanx of the right index finger is especially to be noted. It is the first instance of complete absorption of the diaphysis of bone that I have had an opportunity of observing

PLASTER JACKET—NEW USE FOR.

Dr. McLellan, of St. Marys, Kas., gives the following in the *Lancet and Clinic*, Cin.:— In reading of the uses to which the plaster jacket is put, I have never seen it recommended for the relief and cure of weakened and painful conditions of the spinal muscles, caused by injury, disease, etc., and I think I can make myself more clearly understood by relating two instances from among others, not only where it gave instant relief, but performed a permanent cure. While I was yet a student, (1869, Jan.) I suffered from an attack of typhoid fever, which ran its natural course, and I was convalescent in about eight weeks, and by over-exertion I suffered a relapse, which lasted much longer than first attack. When I got able to be around, I suffered untold agony from pain in the lumbar region and down the course of right sciatic nerve, and at times along the Psoas Muscle, and if I was not near something to catch hold of, would fall, for I could not endure the pain. Cupping, blistering, and all external as well as internal remedies, were

used, but all the relief I could get was from hypodermics of morphia, and I had to take from three to four per day to make living endurable, when I thought the plaster jacket might give me support and relief, and without the aid of anyone I applied a jacket to myself by standing in the position most comfortable, (which was perfectly erect). As soon as the plaster set, I could go around without any pain, and I stopped the morphia then and there, which had got to be considerable, and had no more pain. In less than three months I was perfectly well, and had gained more than thirty pounds, and used no other remedy than the jacket.

CASE 2.—In December, 1883, S. H., aged 19, spare build, came to me, suffering intense pain in the lumbar region and down course of both sciatic nerves. At times the pain was so severe that he would shake as though he had an ague chill. He stated that in September of same year, while making hay, he was helping to put a hay ladder upon the waggon, when the one that was helping him let his hold slip, and all the weight came on him. He sprained the muscles of his back, which grew worse and worse, and, as he stated when I first saw him, he did not want to live the way he was, and as he had already passed through the hands of about three doctors, all regulars, I took it for granted they had used all the usual remedies, so I thought I would try the plaster jacket, and I did so, with the same happy result, no more pain and a rapid convalescence.

OVARIOTOMY IN ENGLAND.—In these days, when continental journals vie with each other in publishing disagreeable remarks about England, it is pleasant to find how, on the other hand, writers in the United States are almost unanimous in sounding praises of our government, our institutions, our towns, our country, and our surgery. *Harpers' Monthly* has just discovered beauties of landscape in the Regent's canal, whilst, in the *Atlanta Medical and Surgical Journal*, the distinguished Dr. Robert Battey devotes an article to a subject which has been looked upon with more pride and interest than that useful waterway by qualified and unqualified Britons, namely, the progress of ovariotomy. The extraordinary results which have been obtained in Great Britain within the past three years, seventy-three consecutive operations in the hands of one surgeon, and seventy-six in the hands of another, without a death, are well calculated, observes Dr. Battey, to excite both astonishment and admiration, American results being far less satisfactory. Dr. Battey, enters into a consideration of the conditions of our success. Experience he considers to be the first of these conditions. If the best results are to be obtained in America, ovariotomy must, he believes, be put into the hands of a few, and the general practitioner must forego the ambition of swinging here and there an occasional scalp to his girdle. The second condition is "clean hands and appliances;" the third, a clean apartment and bedding. The fourth is "pure atmosphere and free ventilation;" and Dr. Battey's allusion to "the upper floors of buildings in elevated urban localities, with surroundings as salubrious as circumstance will admit," probably refers to the Samaritan Free Hospital. The fifth condition is thorough cleansing of the abdomen. Dr. Battey agrees with those English, Scotch, and Irish operators who employ the drainage-tube when the "toilet" of the peritoneum is from any cause incomplete. The sixth condition is skilled nursing and quietude; the seventh, early operation; the eighth, complete intraperitoneal ligature of the pedicle. The last condition of success is antiseptic solutions and spray. He admits that "the results obtained by Dr. Bantock, in London, and Mr. Lawson Tait, in Birmingham, seem to show conclusively that the use of these solutions is not indispensible to the attainment of the best success. They have both shown by their work that scrupulous attention given to the cleansing of hands, instruments and sponges, not only prior to operating, but frequently during the progress of the operation, is sufficient. The frequent removal of the blood from hands and implements appears to protect the abdomen from septic influence." Dr. Battey then speaks of Dr. Keith's objections to the spray. Nevertheless, Dr. Battey himself is not inclined to give up complete antiseptic precautions. He has never had a case of carbolic acid poisoning, and concludes by observing: "To the criticism that carbolic solutions weaker than one to twenty have been shown in the laboratory to be impotent for the destruction of bacteria, I answer that I am seeking by its use only the restoration of my patients to health, and the mortality in my hands since its use has dropped from twenty-five per cent. to zero. This, for me, is sufficient reason for the continuance of the method, and for the rejection of all other substitutes, until such time as more complete demonstrations shall place a clearer light before me." —*Brit. Med. Journal.*

CHLORIDE OF GOLD AND SODIUM IN SOME NERVOUS AFFECTIONS.—In an interesting paper on this subject (*Medical News, Maryland Medical Journal*), Dr. Roberts Bartholow relates some important facts bearing upon the use of gold as a therapeutic agent. Gold is mentioned as a valuable remedy in the treatment of melancholy in medieval history, and afterwards it was used by the Arabians and Italians. Its therapeutic powers are grouped under three heads:

1. According to its so-called alterant effects.
2. According to its action on the nervous system; and

3. According to its urino-genital properties.

Referring to the preparations used, Dr. Bartholow prefers the double chloride of gold and sodium, which he prescribes in the dose of one-twentieth of a grain. In this quantity, twice or three times a day, it appears to have, as its primary action, the power to promote constructive metamorphosis, to improve the globular richness of the blood; and to increase tissue-strength. The tissue yielding most readily to its use are the connective, and especially those of pathological formation. Hence the remedy is considered especially useful in sclerosis, whether nervous, hepatic or renal. In posterior spinal sclerosis, and in chronic interstitial nephritis, Dr. Bartholow has found the gold salt very efficacious. When used in locomotor ataxia, early and persistently, it has seemed to him to have the power of arresting the disease. Dr. Bartholow has observed excellent results following the use of the gold chloride in many cases of fibroid kidney. In a form of hypochondriasis, coincident with the onset of degenerative changes in the cerebral vessels, he has found gold and sodium chloride very effective. When persistently used, the uneasiness in the head, the vertiginous and other abnormal sensations subside, the mental oppression at the same time clearing up.

In certain affections characterized by spasm, as asthma, laryngismus stridulus, and singultus, Dr. Bartholow has seen this remedy act surprisingly well. In urino-genital affections the gold has great value, and cases of chronic albuminuria have been observed in which the curative effects of the remedy have been most conspicuous.

In certain cases of sexual debility, in dysmenorrhœa with scanty menstruation, and in chronic metritis the persistent administration of gold and sodium chloride has done much good. Dr. Bartholow indicates the direction in which the remedy promises to be useful, but is of the opinion that wider and more varied experience is necessary to fix its real position. It seems to us from this statement, made by Dr. Bartholow, that the remedy in question possesses very valuable powers, and is destined to awaken considerable interest. Its actions and uses are worthy of most careful study.—*Medical Review.*

RUPTURED EXTRA-UTERINE PREGNANCY.—Another woman has passed from health to the grave in a few hours; another home has been made desolate; and another victim to delay and palliative hypodermatics of morphia and brandy-and-water in drachm doses has been added to the list, already too long, of cases that have been lost for want of surgical treatment.

A case has been recently reported, in a western medical journal, in which the symptoms of rupture of an extra-uterine fetal sac were complete, and the diagnosis of extra-uterine pregnancy was concurred in by three practitioners, and the following treatment adopted: "Sulphate of morphia in one-sixth-grain doses, hypodermatically, to control the pain, and brandy, both by the mouth and under the skin, as a stimulant. A sinapism over the stomach and bowels assisted in giving some measure of relief." The patient died in sixteen hours and a half. Nothing is said of an attempt to control the hemorrhage, which every one must have known was draining away the woman's life. Nothing is said of a desire to open the abdominal cavity to stop the hemorrhage and remove the foreign body. Is the recorded experience and the teachings of the surgical leaders of the day to go for nothing? Are there any who think that a patient in this situation dies of aught else save hemorrhage, and controllable hemorrhage? If the hemorrhage be not controllable, why do the patients live for sixteen and twenty or thirty hours after the rupture? Are there those in the profession who do not know that the mere exposure of the abdominal cavity to the air will often check a hemorrhage which would otherwise prove fatal in the closed cavity? Surely in these days of great and brilliant triumphs in abdominal surgery, when patients recover after intestinal wounds, and resections, when the most desperate "forlorn hopes" recover, one should not hesitate to open the abdomen in a case of this kind, when two or three ligatures and some clean water are all that are required.

There is no palliative measure for a ruptured extra-uterine cyst; there is no expectant treatment; and there is no other way known to medicine by which a woman in this condition can be reasonably expected to survive save by the prompt use of the knife—and there is no reason for thinking that she would die if this be resorted to in time. And until she is practically dead it is never too late to try and save her.—*N. Y. Med. Record.*

SUBPERIOSTEAL AMPUTATION.—A paper by Dr. Nicaise, read at the International Medical Congress in Copenhagen, is published in the *Revue de Chirurgie*, No. 12, 1884. In 1859 M. Ollier first demonstrated the utility, in amputating, of preserving periosteum, in order to close the medullary canal, and to favor union by primary intention. At this period, however, the suppuration that almost constantly attended the healing of stumps rendered attempts to preserve this membrane quite useless, and so for a time they were abandoned. Since the introduction into surgery of Lister's antiseptic method, further trials have been made under the improved conditions, and the practice has been advocated by Esmarch, Volkmann, Maas, Trelat, and others. Since 1881, Dr. Nicaise has in amputating always preserved a portion of periosteum beyond the end of the bone. As this

membrane retracts very much when detached from its bone, it is thought always necessary to take up a long 'cuff,' the length of which should be about equal to the diameter of the bone at the point of section. Esmarch and Maas bring together the the free edges of the process of peritoneum by a suture of prepared catgut; Nicaise does not apply a suture, but allows the long cuff to form over the end of the bone a kind of hood. It has been proved by experiments on animals that a flap or loose process of periosteum rapidly closes the open end of the medullary cavity, and that on the inner surface of this occluding membrane a thin layer of osseous tissue is formed. M. Nicaise alludes to a case of amputation of the thigh for chronic disease of the knee in a tuberculous man, aged 42. After death, which occurred twenty-nine days later, when the stump had almost entirely healed, the lower extremity of the divided femur was found completely closed by a septum of thickened and granular periosteum, above which was a layer of newly formed bone-tissue, about one-fifth of an inch in thickness. It has been shown by LeFort and Trelat that a minute flap of muscular tissue brought over the end of a divided long bone will contract adhesions, close the medullary cavity, and even form a thin layer of osseous tissue. M. Nicaise, however, holds that, when a flap of periosteum is applied, the end of the bone is in immediate relation with a membrane that physiologically is best adapted to the purposes of protecting and forming osseous tissue. It has been objected to the preservation of periosteum in amputation, that this practice favors the formation of irregularly shaped osteophytic growths. Such growths, however, according to the author, are formed only after suppuration in the stump, or osteitis at the extremity of the bone.—*London Med. Record.*

POISONED BY COLORED STOCKINGS.—Again and again have medical journals warned against the wearing of cheap colored underwear. As these materials generally consist of cotton, at least to a great extent, the coloring stuff is not always an innocuous, but frequently a dangerous one.

The latest case of this kind is reported by Dr. O. Seifert, in the *Wiener Med. Wochenschrift*, 1885, 38. A young lady æt. 26, had been wearing stockings, which had been colored by an anilin-red, containing a large percentage of arsenic. She was suddenly seized with all the symptoms of a gastro-enteritis and an acute hæmorrhagic nephritis; besides, an eczematous skin-eruption made its appearance on the dorsal surfaces of both feet. The treatment first gave a very unsatisfactory result, until the cause was discovered, when the patient was cured of her disease within three weeks. The urine, however, for a considerable time afterwards, contained a small amount of albumen, though this finally also disappeared.

There ought to be a sanitary inspector, not only for all food—whether solid or fluid—that is offered for sale, but also for articles of wear. The demand for cheaper goods, and the great competition, has made many manufacturers reckless, and they seem to care very little if they injure the health of individuals, if they can only produce goods which are cheap and showy. As not every buyer can be an expert, purchasers ought to be protected by law, making the poisonous or any adulterations of any article offered for sale, a criminal offence, and appointing inspectors for the purpose of investigating and discovering all dangerous swindles of that kind. Meanwhile, it would be best for all buyers to avoid all cheap articles, which mainly attract attention by their bright colors. In wool, the danger is not so great, as woolen materials may be easily dyed by innocuous vegetable coloring matters.—*Med. & Surg. Reporter.*

THE TREATMENT OF WHOOPING COUGH.—The treatment of this disease should be of two characters, one of which is addressed to the catarrhal and the other to the nervous element. Considering the bacterial nature of the disease, antiseptics form one necessary class of agents for treatment. Oxygen in the form of an abundance of pure air is always indicated. The sick-room should be kept at an uniform temperature and the air moistened with spray, either of simple steam vapor of lime, of carbolic acid, corrosive sublimate, listerine, muriate of ammonia, or cocaine. Thymol, eucalyptus or quinine, may be used in this form. The following formulæ for use with the spray are recommended:

R.	Acidi carbolic cryst.	3 grs.	
	Sodii bi-boratis		
	Sodii bi-carb. aa	20 grs.	
	Glycerinæ	1 oz.	
	Aquæ	1 oz.	M.

R.	Thymol	15 grs.	
	Alcoholis	3 dr.	
	Glycerinæ	½ oz.	
	Aquæ	34 oz.	M.

The inhalation of a few drops of ether or chloroform is recommended when the paroxysms are violent. Of emetics, alum is thought to be the best, a quarter or half a teaspoonful being given with syrup or honey, and repeated if necessary. In the mean time the child may be placed upon its stomach, with the head lowered. Of nervous sedatives, belladonna is the best for this trouble, and may be given in suitable doses of the tincture, or in the form of the sulphate of atropia, $\frac{1}{100}$ of a grain at a time, increased until the pupils are dilated. The bromides of sodium, ammonium, or potassium may also be given, and in many cases chloral is very useful. Of the latter, for a child one year old, two grains may be given at bed time. Of

quinine, a grain may be given several times during the day with good effect. The foregoing list may be increased by the addition of pilocarpine, benzoate of sodium, salicylic acid, sulphur, cantharides, calomel, and soda, etc. Counter-irritation is an important measure, a mixture of croton oil, oil of amber, and oil of cloves, mixed with sweet oil, and rubbed upon the neck or chest, being recommended. The bowels should be kept freely open, heat applied over the lungs if they appear to be implicated, and a nourishing diet with a suitable quantity of stimulants administered.—*Archives of Pediatrics.*

INCONTINENCE OF URINE IN CHILDREN.—Eustace Smith gives the following in his recent work: "Of medicines which diminish irritability, belladonna takes the first place, but it is important to be aware that this remedy to be effectual, must be given in full doses. Children have a very remarkable tolerance for belladonna, and will often take it in surprising quantities before any of the physiological effects of the drug can be produced. In obstinate cases of enuresis the medicine should be pushed so as to produce dilatation of the pupils, with slight dryness of the throat. In children of four or five years of age, it is best to begin with twenty-five or thirty drops of the tincture of belladonna, given three times in the day, and to increase the dose by five drops every second or third day, of course watching the effect. Ergot is another remedy which is often very successful. For a child of the same age, twenty drops of the fluid extract may be given several times in the day.

Bromide of potassium, benzoic acid (dose, five to ten grains) and benzoate of ammonia, digitalis, borax, cantharides, camphor and chloral have all been recommended as specifics in this complaint. Sometimes a combination of several drugs seems to be more effectual than one given alone. I have lately cured a little girl, aged four years, who had resisted all other treatment, with the following draught given three times in the day:

℞ Tinct. belladonna.....gtts. j.
Potas. brom .....grs. x.
Infus. digitalis .....℥ ij.
Aquam ad.....℥ ss.
M. Ft haustus.

When the incontinence continues in the day as well as at night, strychnia should be combined with the sedative, so as to give tone to the feeble sphincter. In these cases, too, cauterization of the neck of the bladder, with a strong solution of the nitrate of silver (℈j—℥ j. to the ounce of water) has been found successful."

VALUE OF "THE DIAGONAL LINE" IN THE DIAGNOSIS OF DISTENSION OF THE GALL-BLADDER.—John W. Taylor, F.R.C.S, Birmingham and Midland Hospital for Women, says: In an article on cholecystotomy in the *British Medical Journal* of January 31, 1885, I wrote as follows: "An important aid to diagnosis will, I think, be found in recognition of the diagonal line in the direction of which the gall-bladder enlarges. This is to be traced from the normal position of the larger end of the gall-bladder (near the tip of the cartilage of the tenth rib on the right side) to the opposite side of the abdomen, crossing the middle line slightly below the umbilicus."

Since writing the above, I have had some additional opportunities for testing the value of this aid to diagnosis. On February 15, 1885, I was asked to see a case of abdominal tumor by my friend Dr. Drury. There was no jaundice, and but little clinical history to be obtained in the limited time at my disposal. Finding, however, a well defined, hard, but rather resilient tumor, the longer axis of which exactly corresponded to the diagonal line described, I had no hesitation in diagnosing the case to be one of distension of the gall-bladder.

This opinion (in which Dr. Drury concurred) was considered erroneous by another surgeon of large experience, who saw the case subsequently; and, as the chief reason for my opinion was the sign which is the subject of my communication, the case became of some special importance to me as a test.

On March 26th Mr. Tait operated. The tumor proved to be a distended gall bladder; and a large number of calculi were removed from it, two of these being of enormous size.

I should like to again draw the attention of the profession to this diagnostic line, as I believe it to be trustworthy and useful.—*British. Med. Jour.*, April 11th.

BELLADONNA INJECTION FOR GONORRHŒA.—Some thirteen years ago an officer on board one of the vessels of the Indus Steam Flotilla consulted me for a bad gonorrhœa with intense pain on micturition, and intolerable chordee at night. The case was urgent, and I ordered an injection composed of seven ounces of water, an ounce of mucilage acacia, twenty grains extract of belladonna, and twenty grains of sulphate zinc, a teaspoonful to be injected immediately before and after micturating, and a similar amount the last thing at night; great care to be used in passing the injection fully down as far as the pain is most intense. An ointment of spermaceti and mercurial ointment, four drachms each, and ten grains extract belladonna, ten grains powdered opium, as a paste to be smeared along the perineum and around the crura penis at night. Patient left next morning, having had no chordee that night, and the pain of micturition disappeared by using the injection. Within a week there was complete cure. From that time I have had numerous gonorrhœal cases of every type and stage, and without exception with unfail-

ing success. Not long since a shop assistant presented himself with a bad gonorrhœa, high fever, inflamed testicle and chordee at night. With the application of the belladonna and opium ointment the chordee did not appear, and in four days after using the injection the running ceased, but after the first application the pain and running were much lessened. A suspensory bandage was worn, and with the daily use of the mercurial and belladonna and opium ointment the patient was quite well in three weeks. Patients have always stated that it is the injection, and not the ointment, which stopped the chordee. I have tried the anodyne treatment in various classes of people, from the dissipated paupers of the Eastern bazaars to the well-fed *roue* in the West; in the acute and in the chronic and gleety stages; in first attacks, and in those making one of a series; and in cases complicated with inflamed testicles and chordee; and I have no hesitation in saying that I have not witnessed anything to contra-indicate it nor to mitigate its success.—John Roche, M.D., in *Medical Press.*

THE INJECTION OF HOT OR COLD WATER IN UTERINE HÆMORRHAGE.—Dr. Schwarz relates a case of post-partum hæmorrhage which was controlled temporarily by an injection of water at a temperature of 120° F., containing two and a half per cent. of carbolic acid. The bleeding began again, however, and could not be arrested by further hot-water injections. A trial was then made of ice-water with perfect success. In other puerperal and non-puerperal cases, after failure with hot water, the author obtained most satisfactory results with cold injections. Dr. Graefe has also had several cases in which he found cold irrigations to answer the purpose after hot water had failed. He regards the styptic action of hot water as due not only to the swelling of the tissues which it causes, but also to a certain degree of muscular contraction in the uterine walls. The former is not sufficient in itself to arrest the hæmorrhage unless aided by muscular contraction. When cold water irrigations follow those previously made with hot water, strong contractions of the uterine muscles are excited, but the œdematous swelling caused by the hot water can not be so rapidly overcome, and hence the two conditions most favorable for arresting the hæmorrhage are present. In the same way when hot injections follow cold ones, the irritation to the muscular tissue remains, and to it is added the swelling of the tissues above mentioned. If only one be used, Schwarz prefers the cold water, as having the advantage of absolute safety. Hot water, if too hot, may cause a paralysis of the uterine muscular tissue, and if not hot enough will only increase the hæmorrhage. If a trial with one temperature be unsuccessful, the use of the opposite will almost certainly control the bleeding.—*Schmidt's Jahrbucher, No. 7, 1884; Med. Record.*

SWALLOWING OF ARTIFICIAL TEETH.—Artificial teeth have probably been often swallowed. Too hard for digestion and not provided with sharp-pointed edges, as a rule, they cause very little inconvenience. More dangerous is the swallowing of whole sets, as in such a case a plate, with all its hooks and pointed edges, has to pass through the pylorus and the ilio-cæcal valve. If it were possible, after such a plate has been inadvertently swallowed, to send some substance after it that could envelop the pointed and "hooky" plate with a material which might remove the sharp points, the greatest danger would be removed. But thus far this substance has been a desideratum unfulfilled. In the April 13, 1885, number of the *Deutsche Med. Zeit.*, however, we find a communication which, on account of the ingenuity of the procedure, and of its complete effect, is highly interesting and deserves further dissemination through the columns of the *Medical and Surgical Reporter.*

A dentist named Geisselbrecht, in Fürth, was sent for one night by a servant girl, who, during sleep, had swallowed her artificial teeth. The set consisted of a rubber plate with four canines and two bicuspids, which plate was attached by the aid of gold clamps to the natural teeth. On examination, the neck of the girl was found to be swollen and painful to the touch in the region of the larynx. The examination of the pharynx gave no result; the set had disappeared; but with the use of the œsophageal sound it could be felt. But as the plate had already passed too deeply, there was no prospect of its being extracted, and G. pushed it with the sound into the stomach through the cardiac orifice.

Now comes the interesting part of the procedure. That the plate might pass on through the intestinal canal without injuring the latter, G. induced the girl to swallow a lot of cotton thread (spool cotton), which was first cut into small pieces and incorporated in the white of an egg beaten to snow. The intention was to have the threads steeped into the white of the egg, wrap themselves around the sharp points of the plate and thus prevent their injuring the intestines.

The result has been a brilliant one; four days later the girl brought the ominous plate, and the latter was found to be completely enveloped, overspun, as it were, by the cotton threads. The patient said that she had no pain, or any other inconvenience either, while the plate was resting in the bowels or during its passage out.—*Med. and Surg. Reporter.*

THE TREATMENT OF CHOLERA.—The current number of the *Practitioner* contains the concluding paper of the interesting series that have been published in that journal by Drs. Lauder Brunton and Pye-Smith, in the course of which they have dis-

cussed the present knowledge of the pathology of cholera. Speaking of the treatment of the disease, they divide remedies into five classes: of these, three contain remedies which act on the intestine. They are—1. Those which are likely to have an antiseptic action on the intestine by destroying any organisms there present, such as carbolic acid and its allies, sulphurous acid, nitro-muriatic acid, hyposulphites, permanganates, chlorine, chloralum, turpentine, salts of copper, boracic acid, calomel, and corrosive sublimate. The cholagogue action of calomel is thought to be of service by inducing indirectly the antiseptic action of bile. 2. Those remedies which will tend to remove the cholera poison, whether it consists of living organisms or of some chemical substance, exemplified by the treatment by castor oil and other purgatives. 3. Those remedies which will counteract the effect of the poison upon the intestinal canal, as opium, morphia, ice water, belladonna, cannabis indica, chloroform, chloral, carminatives, and astringents. 4. Remedies which will tend to eliminate the poison from the system, as copious draughts of water (as diuretic) and purgatives. 5. Those remedies which will counteract the effects of the poison—viz., intravenous injection of saline fluids and other substances, and various measures to restore the circulation by acting upon the skin. In dealing with the premonitory diarrhœa, Cantani's method of injections, by means of the long intestinal tube, of laudanum and tannic is described. The authors consider that Ferrán's results of inoculation are more favourable than could have been expected, and point out the following as "directions in which further researches after a remedy for cholera are most likely to prove successful":—"1. The discovery of an antiseptic which will destroy pathogenic organisms in the intestines and prevent the formation of the cholera poison, while they are not themselves poisonous. Corrosive sublimate is a sufficiently powerful antiseptic, but it may itself prove poisonous to the patient as well as to the pathogenic organisms. It is possible that amongst the members of the aromatic group of bodies substances may be found having the desired properties. 2. The discovery of some substance which will antagonise the action of the cholera poison after its absorption. As a preliminary step in this direction further experiments are needed in the nature and action of alkaloidal substances obtained from cholera dejecta, as well as from artificial cultivations in various media and under various conditions, electrical and otherwise. 3. Observations on the effect of stimulation of the mesenteric plexus by currents passed through the uninjured abdomen in poisoned animals and in patients suffering from the disease." —*Lancet.*

TREATMENT OF SCROFULOUS NECK.—Dr. Clifford Allbutt, in a recent lecture, affirms that the chronic enlargement of the glands of the neck, known as scrofulous neck, is secondary to irritation in the associated mucous membranes, and absorption therefrom; the chief of these being the mouth and throat, and the next in order the nasal, aural, and ocular surfaces; and sometimes from irritation upon the skin of the face and head. Speaking of the treatment of these cases, the author says that a residence at Margate, together with careful dieting and nursing, is the best means of cure in cases which are not far advanced. The cautious use of mercury, such as the solution of the bichloride, with tincture of iron, is very good, unless the inborn frailty be very marked; and iodides with iron are likewise valuable. External applications should be used with caution. So soon, however, as the glands become adherent, either to each other or to the surrounding tissues, then it is most desirable to call in the surgeon, and to extirpate every caseous gland or portion of a gland. Mr. Teale has devoted much time and has had great experience in operating on these cases, and it is due to the combined exertions of Dr. Allbutt and Mr. Teale that numerous cases have been restored from a state of misery to enjoy a life of comparatively good health. The scar remaining after the operation is small, and after a year or two not very noticeable, provided the drainage be not kept up too long; it is better to risk a second operation than to keep the drainage-tube in for too long a period.

DIFFERENTIAL DIAGNOSIS OF SIMPLE AND TUBERCULOUS MENINGITIS.—In an analysis of a number of cases of meningitis occurring in the Children's Hospital at Stockholm, Dr. O. Medin endeavours to formulate the points of difference in the tuberculous and simple forms of the disease. Tuberculous meningitis attacks only those children already suffering from tuberculosis of other parts, while simple acute meningitis occurs usually in previously healthy individuals. The former manifests its onset by convulsions, frequently strabismus, and dilatation or contraction of the pupils. Vomiting is frequent at the commencement, diarrhœa is the usual condition, and constipation is rare. The abdomen is never flat. The simple form begins with somnolence, twitchings, sudden changes of color in the face, and hyperesthesia. More frequently than in the tuberculous form we meet with the hydrocephalic cry, and a paralysis limited to the arms or to the face. The tuberculous variety is always fatal in its termination.—*London Practitioner.*

TREATMENT OF VARICOCELE BY EXCISION OF A FOLD OF THE SCOTRUM.—At a recent meeting of the Académie de Médecine, Horteloup rememmended a plan of operation which he has practiced for several years with success. He pushes the

testicles upwards, and seizes with a long pair of forceps a fold of scrotum containing the plexus of the spermatic veins. Deep sutures are passed immediately in front of the forceps and fixed by leaden tubes; a row of superficial sutures is then placed a little nearer the edge of the fold, which is afterwards excised. The superficial sutures are tied, and an antiseptic dressing is applied to the wound. M. Horteloup has performed this operation in eighteen cases without any serious accident, and expresses himself much pleased with the ultimate results —*London Med. Record*, April.

DIAGNOSIS OF GONORRHŒA IN THE FEMALE.—Martineau, at a recent meeting of the Paris Obstetrical and Gynecological Society, stated a most important fact by which specific can be distinguished from simple vaginitis. It depends upon this that in the specific form of the disease the pus is always acid, while in the simple it is alkaline. It is very easy, therefore, to decide by a piece of litmus paper as to whether a woman is or is not suffering from gonorrhœal inflammation.

This sign will prove of value, too, in determining, when rape has been committed, whether the person committing the crime was affected with gonorrhœa, for then the vulvitis would be characterized by an acid discharge, while in the simple form of the disease the discharge is alkaline.—*Med. News*.

ACUTE ABSCESS.—Prof. S. W. Gross says it is a mistake to apply a poultice to an abscess after its contents have been evacuated The endeavor should be to prevent and not encourage the formation of pus. To do this the cavity of the abscess should be syringed out with a 1 to 1000 solution of mercuric bichloride, and the walls brought together by compresses and bandage, and union allowed to take place by granulation. If the abscess be of large size a drainage tube should be left in for a couple of days until the serous oozing has been reduced to a minimum. The tube should then be taken out and the walls brought close together. If the healing process be delayed by the development of flabby œdematous granulations they can be stimulated to healthy action by the injection of a three per cent. solution of carbolic acid or the application of chloride of zinc gr. iij., aqua ℥j.—*Med. Bulletin*.

TREATMENT OF SPERMATORRHŒA.—Dr. Nowatschek reports in *Schmidt's Jahrbucker*, January, 1881, a case of spermatorrhœa consequent on typhoid fever, the diagnosis resting on the presence of spermatozoa in the fluid which was constantly oozing from the urethra. Iron, quinia, and cold applications to the genitals were tried in succession with some success, but a cure was not accomplished. Lupulin, camphor, and bromide of potassium were without effect. Atropia was then employed, and the patient was completely cured in five days. The author cites a second case where he was equally successful with the hypodermic injection in the perineum of a one per-cent. solution of atropia.—*Jour. de Med. de Paris*.

ANTIPYRIN.—This new antipyretic, is now advanced to the position occupied by quinine, salicylic acid, etc. Dr. A. C. Girard, assistant-surgeon in the U. S. Army, in the *Medical News*, speaks very positively in regard to its usefulness as an antipyretic. He says it reduces the temperature without evil concomitant; the fall of temperature begins one or two hours after ingestion of the remedy, and its effects last from seven to twelve hours. It does not seem to shorten the disease for which it is given, but surely lowers the temprature, and thus prevents the rapid waste consequent upon the high temperature. The dose advised is from fifteen to thirty grains, or even more.

A METHOD OF TREATING PRURITIS ANI.—A correspondent of the "*British Medical Journal*" suggests the following plan of treating this distressing affection: Wash the external parts well with warm water, and inject a small amount of water into the rectum. Then introduce a ball of cotton saturated with a lotion consisting of:

Carbolic acid	20 grains;
Laudanum	4 drachms;
Dilute hydrocyanic acid	2 "
Glycerin	4 "
Water, enough to make	4 ounces.

The pledget should be removed before defecation, and a fresh one introduced after the act.—*N. Y. Med. Journal*.

RAPID BLISTER.—It is sometimes desirable to produce a small blister quickly. For this purpose nothing is better than concentrated water of ammonia (*aqua ammoniæ fortior*). Put a few drops of it in a watch crystal, or any receptacle of the sort, cover it with a pledget of absorbent cotton, invert on the spot to be blistered, and press closely. In half a minute or so a red circle will appear on the skin around the edges of the confining vessel. It is an evidence that vesication has taken place, and the blistering material can be removed. The blister should be treated in the same manner as one obtained from cantharides.—*Southern Clinic*.

COD-LIVER OIL AND LIME-WATER IN SCALDS OF THE THROAT.—Palmer ("*Practitioner*"), referring to the frequency with which young children are scalded by drinking from the spout of a tea-kettle, speaks highly of the therapeutical value of teaspoonful doses of lime-water and cod-liver oil (equal parts). In a severe case treated by him the patient received a teaspoonful of this novel "car-

ron-oil" every hour. The pain was promptly relieved, the child was soon able to swallow, and within a few days recovery was assured. The writer does not give a very satisfactory explanation of the *modus operandi* of the remedy.—*N. Y. Med. Jour.*

SUPPORTING THE PERINEUM.—In the *Clinique d' Accouchements*, at Paris, Depaul in one of his last lectures said: "I *never* support the perineum; I am contented with supporting the head of the fœtus and preventing it from emerging too suddenly." Often, when the perineum has been supported, it has been found on withdrawing the hand that a rent has been made in the perineum by the hand itself. For this reason Depaul said, support the head, but leave the perineum alone.—*N. Y. Med. Times*, April.

CHRONIC DYSENTERY.—Prof. Da Costa finds sulphate of copper, gr. $\frac{1}{12}$–$\frac{1}{8}$, four times a day, combined with opium, to be very effective in chronic dysentery. Other remedies he finds useful are bismuth, especially in children; nitro-hydrochloric acid, zinc sulphate, argentic nitrate, iron sulphate, or Monsell's solution (gtt. iij. -v.), or solution of the nitrate (gtt. xx.-xxx.) All except iron should be combined with opium. When other things fail, small blisters over the spot of greatest soreness sometimes do good. The diet should contain no starches, fruits or vegetables. —*Coll. and Clin. Record.*

TREATMENT OF ECLAMPSIA BY WARM BATHS. —Breus has given in the *Archiv für Gynækol.*, Band xxi., No. 1, the result of his observations in seventeen cases, two of which ended fatally. He recommends putting the patient in a bath at 38° C., and to raise the temperature of the water gradually until it reaches 41° C. After that, the woman is wrapped up in blankets, and abundant perspiration sets in. When albuminuria exists during pregnancy, a course of warm baths may prevent the occurence of convulsions at the time of confinement.—*London Med. Record*, April.

ECZEMA OF THE GENITALS.—

℞ Potassii chloratis	1.50 gm.
Vini opii	2.50 gm.
Aquæ puræ	1 litre.

Apply on a compress. To be preceded by a warm sitz-bath or by mild cataplasms if there is a certain degree of attendant inflammation.—*(La France méd.)—Phila. Med. Times*, April 18th.

PRURITIS OF PREGNANCY—SULPHUROUS-ACID LOTION.—Dr. Powell, Peckenham, writes in answer to a query: Presuming "A Member's" patient is not diabetic, I would suggest that she apply to the parts affected a lotion of sulphurous acid in warm water (half ounce to the half pint), the results of which I have uniformly found successful.—*Brit. Med. Jour.*

APPLICATION IN ORCHITIS.—The following formula is highly endorsed a sa local application in orchitis:

℞ Iodoformi	ʒ j.
Thymol	gr. iv.
Vaseline	℥ j.

M.—To be applied greased on linen.
—*Med. World*, April.

EXTRA-UTERINE PREGNANCY. — In a recent number of the *Brit. Med. Jour.*, Mr. Lawson Tait reports three cases of tubal pregnancy, with consequent rupture of the tube, in which laparotomy was performed successfully. Mr. Tait has now saved eight women out of nine in whom a similar condition existed. This is a remarkable record, and we do not know which most to admire, the accuracy of the diagnosis or the promptness with which the emergency was met. In Mr. Tait's opinion all cases of extra-uterine pregnancy are of the tubal variety.—*N. Y. Med. Jour.*

HEPATIC COLIC.—In a case of hepatic colic with a tendency to the formation of biliary calculi, Prof. Bartholow prescribed:

℞ Sodii cholat	gr. xxx.—xl.
Extract, nucis vomicæ	gr. ijss.

M.—Fiant pil. x. Sig.—One pill ter in die.
The cholate of sodium will help to keep the bile in a soluble condition.—*Med. Bulletin*, April.

DYSPEPSIA.—The following will be found excellent in cases of dyspepsia either chronic or acute: ℞ Elix. pepsin ℥ iss., bismuth sub. nit., ʒ i., fl. ext., hydrast, canadensis, ʒ iss., Tr. lavander co., syrup. simplex, equal parts, q. s. ad., ℥ij. M. Sig.—Teaspoonful 3 three times a day before meals.—*Med. World.*

WHENEVER a case of scrofulous disease was presented at his clinic, in the person of a child *whose father had been in the army*, the late Prof. Gross, asking no further questions, would turn to the class with the single, but significant, remark, "*Specific*, gentlemen!"

TRACHEOTOMY in diphtheria saves but few persons who take the disease in severe epidemics, according to Dr. Jacobi. This opinion is founded upon fifty consecutive unsuccessful tracheotomies during a period of two years.

DR. LEWIS A. STIMSON has been elected Prof. of Anatomy in the University of the city of New York, to succeed the late Prof. Darling.

THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science Criticism and News.

☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, JULY, 1885.

The LANCET *has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

PHYSICIANS' WORRIES.

It would be hard to name a class of men more the victims of worry than medical men. It is not to be presumed that this arises from anything inherent or exceptional in the constitutional make-up of medical men. The young men who come up from every grade of society to learn the mysteries of medicine, are as free from the cares of life, and as buoyant in temperament, as mankind produces. Indeed, we venture to remark, that for unselfishness, present enjoyment of life, and freedom from the forebodings of the ills the morrow may bring, they stand pre-eminent. How then does it come, that so large a number in after life become unhappy, care-worn, and wind up their mortal career at a much earlier period than men of other walks of life? The very fact of medical men dying off, before their time, so to speak, goes a long way to support the commonly-made assertion that the physician leads a life of toil and worry. Of course we all know that there are many exceptions. There are those who, however much they toil, do not worry—and are always cheerful and contented amidst even the most unfavorable environments. Amongst these we may safely class all the octogenarians dead or living, for it is rare indeed that the man who is bowed down from early manhood by a load of anxieties and troubles reaches even his allotted three-score and ten years, no matter what his calling or circumstances in life. It is said, and said truly as regards mental work, that it is worry and not work that kills. True, the work of the busy physician is anomalous inasmuch as severe physical exertion has to be borne along with the mental strain inseparably associated with the performance of duties, in their very nature weighty and critical, and hence demanding, almost constantly, the full exercise of the intellectual faculties. In this respect the practice of medicine, we believe, is unique. This of itself would, to some extent, account for the anxieties which perpetually harass the conscientious physician, and tend to make him short-grained and grey-haired before his time.

But the struggle for existence is by far the largest factor in the medical man's troubles. As he looks on his wife and children and reflects what little provision he has hitherto been able to make for their future wants; or, worse still, finds himself unable to meet present demands, and yet is obliged to maintain himself and family in a manner becoming their station,—he naturally begins to feel uneasy. "The narrower the pit the fiercer the fight," and the knowledge that others are making a dead set on what is barely enough for himself, is a fruitful source of worry, and to most natures unavoidably so. Under such circumstances he feels it imperatively necessary to guard his little patronage with the utmost care and watchfulness, sparing neither physical nor mental effort to ward off the approaches of those whom necessity compels him to regard as intruders and enemies. And thus has it come to pass, in all civilized countries, that the majority of the members of a humane and noble profession are so hotly engaged in a competition, involving no higher issues than bread and butter, as to rob them of needed rest and recreation, induce feelings of jealousy and enmity, culminating in a state of hopeless, chronic worry. We must not omit to mention that a good many, "blessed with enough and to spare," may also be placed in the above category. It is a pity it should be so, but we all know that our profession has its mercenary members like all other callings, and not a few either. Instead of lending a helping hand to the beginner, or to an unfortunate or distressed brother, they are found engaged in a perpetual war of extermination, waged on the Darwinian theory, that the fittest alone has a right to survive!

It is a subject of common remark, that medical men are more than usually sensitive in the matter

of criticism. This is probably true, but there is a reason for it, and that is, that his reputation is the medical man's whole stock-in-trade. When that is wantonly assailed, as too often happens, but few can stoically remain unmoved. This is all the more difficult, because such adverse criticism usually comes from persons wholly incapable of judging in medical matters, and generally is uncalled for, ungenerous, and foundationless. No calling is so much exposed to the assaults of the ignorant and malicious, and no form of slander is so difficult to disprove, or to arrest on its rounds, as that which falls to the lot of the physician.

We might also refer to the nature of the work the physician has to perform. His mission is not to the gay and happy, but to the downcast and miserable. His path lies through sickness, suffering and death, and the gloom which overhangs such scenes. It would be easy to name other troubles peculiar to our calling, but let this suffice for the present. While most of our worries are inherent to our duties, it must be confessed that they are greatly aggravated by our own imperfections, and instead of unduly magnifying them, it should rather be our aim to reduce them to a minimum, and heroically resolve to endure what cannot be amended. But the picture has another and brighter side. Medical men are messengers of "peace and good will to men," in a less high degree of course than spiritual messengers, but such they are nevertheless. The binding up of wounds, the alleviation of pain, the removal of disease and restoration to health, hope and the enjoyments of this life, is a mission so beneficent and exalted as to afford, in quiet moments, much joy and satisfaction to all who engage in it, and rightly apprehend its true nature. Were more of this spirit to prevail and less of the mercenary, many of the ills of which we complain would disappear, and the profession of medicine would be greatly elevated in the estimation of its membership and the public generally. But such a thought is too Utopian for serious mention in the present utilitarian condition of society.

Charity begins at home, and every man owes a duty to himself and his household. Of the duties thus imposed but few are as important as the cultivation of a cheerful, hopeful disposition. There is wealth, health and happiness in it. To do this successfully, the medical man needs helps. Let him have some hobby, some means of diversion to lift him for a few hours, at least, out of his well-worn ruts. He should not hesitate, nor consider such time lost, to take a holiday now and again. The freshness and vigor of both body and mind acquired more than compensate for the time and money spent. We owe to our patients the sunshine of a cheerful and happy manner. The sick need encouragement, and all the inspiration to be derived from a hopeful disposition and buoyant spirits. Let the doctor not withhold these potent adjuncts when called upon to prescribe. They are not only cheap but marvelously efficacious as well.

ONTARIO MEDICAL COUNCIL.

The first meeting of the newly elected Council of the College of Physicians and Surgeons of Ontario was held in this city on the 13th ult., and following days. All the members were present, and the business of the College was promptly and faithfully attended to. Dr. Bergin, M.P., of Cornwall, was elected president, and Dr. Douglass, of Port Elgin, vice-president. The secretary and treasurer were re-appointed, and many new names were added to the various standing committees. Some interest was taken by members in regard to those students who went to the North-West as dressers and were thereby prevented from taking their primary examination. After some discussion and supported by the opinion of the solicitor, the Council very wisely decided to allow the students so situated their primary examination. The curriculum was not disturbed, save in one respect, viz., the placing of arts graduates in the same position as mentioned in last year's announcement, *three* years' medical study only being required, instead of four as was proposed last year. In the matter of registration, it was decided to make the registration fee $25, instead of $10 as at present. This was deemed necessary, owing to the loss of fees sustained in consequence of a number of students qualifying in Great Britain, who were admitted to registration on their return on payment of the small fee of $10, while those who took the Council examinations were required to pay $60. The fees for the primary and final examinations will be correspondingly reduced, so that the fees for those who take the Council examination will be the same as heretofore. The examining board of last year

was re-appointed, no change being considered advisable at present. It is gratifying to observe that the spirit of intermeddling with the regulations of the Council, so much in vogue a few years ago, has given place to a settled determination to make changes only when they appear after due consideration to be essentially necessary in the interests of the college. With regard to the site for the college building, it has been suggested that the Council retain the present site on the corner of Bay and Richmond streets, and erect a large building, three storeys in height; the lower storey to be rented for business purposes, and the upper storeys reserved for the use of the college. The proposal seems a very good one, and a committee has been appointed to consider the whole matter.

NEW INTERPRETATION OF THE CODE.

A committee of the American Medical Association was appointed last year, consisting of Drs. N. S. Davis, Chicago; Austin Flint, sr., New York; H. F. Campbell, Augusta, Ga.; A. P. Garnett, Washington; and J. B. Murdock, Pittsburgh; to report on the interpretation of certain clauses of the "code" which have been differently understood. The following liberal interpretation by the eminent men above-named, was received and adopted by the Association at its recent meeting in New Orleans, and has met with the approval of the profession generally:

Whereas, Persistent misrepresentations have been and still are being made concerning certain provisions of the Code of Ethics of this Association, by which many in the community, some in the ranks of the profession, are led to believe its provisions exclude persons from professional recognition simply because of difference of opinion or doctrine; therefore be it

Resolved, That Clause 1, Article IV., in the National Code of Medical Ethics, is not to be interpreted as excluding from professional fellowship, on the ground of difference in doctrine or belief, those who in other respects are entitled to be members of the regular medical profession, neither is there any other article or clause in said Code of Ethics that interferes with the exercise of the most perfect liberality of individual opinion and practice.

Resolved, That it constitutes a voluntary disconnection or withdrawal from the medical profession proper to assume a name indicating to the public a sectarian and exclusive system of practice, or to belong to an association or party antagonistic to the general medical profession.

Resolved, That there is no provision in the National Code of Medical Ethics in any wise inconsistent with the broadest dictates of humanity, and that the article of the Code which relates to consultations cannot be correctly interpreted as interdicting, under any circumstances, the rendering of professional services whenever there is pressing or immediate need of them; on the contrary, to promptly meet the emergencies occasioned by disease or accident, and to give the helping hand of assistance without unnecessary delay is a duty fully enjoined on every member of the profession, both by the letter and spirit of the entire Code, but no such emergencies or circumstances can make it necessary or proper to enter into professional consultation with those who have voluntarily disconnected themselves from the regular medical profession in the manner indicated by the preceding resolution.

MALPRACTICE SUITS.

Two cases for alleged malpractice were tried during the past month in this city. The first was an action to recover $10,000. The parties were John Johnston, of Midland, and Dr. Kidd, of the same place. On June 21st, 1884, the plaintiff's son, twelve years of age, stepped on a piece of broken glass and wounded the arch of his foot severely. Dr. Kidd was called in, and, as there was no hemorrhage at the time, he stitched up the wound and told the parents to send for him if anything untoward occurred. This they did not do. It bled on several occasions up to the 13th of the following month, but not until then was the doctor sent for. The plaintiff claimed that the doctor did not tie the artery, that the foot was bandaged too lightly, and in consequence mortification set in and part of the foot sloughed away, which will necessitate amputation. After a few of the plaintiff's witnesses were examined, it became evident that there was no cause of action against the doctor, and Mr. Osler, Q.C., who appeared for the plaintiff, threw up his brief.

In the second case the plaintiffs were Jas. H. McQuaig, a farmer in Pickering township, and his

wife, who sought to recover damages from Dr. Eastwood, of Whitby, claiming that in November, 1884, during Mrs. McQuaig's confinement and subsequent illness, he treated her negligently and unskilfully. This trial occupied two days, and a number of witnesses were called on both sides. The principal medical evidence on behalf of the plaintiff was the plaintiff's brother-in-law, Dr. Whiteman, of Shakespeare, supported in part by that of Dr. Warren, of Brooklin. On behalf of the defendant, several medical gentlemen in Toronto were examined, all of whom in the main approved Dr. Eastwood's treatment of the case. The counsel for the plaintiff, Mr. Lount, moved twice during the trial to secure a non-suit, and although the judge ruled against him, he finally charged the jury strongly for the defendant. Notwithstanding the judge's charge, however, the jury brought in a verdict for the plaintiff, assessing the damages at $350. The case will be appealed.

ONTARIO MEDICAL ASSOCIATION.

The fourth annual meeting of the Ontario Medical Association was held in London on the 3rd and 4th ult., the President, Dr. Worthington, in the chair. There was a large attendance of members present, and upwards of thirty papers on the programme. It therefore became necessary on the second day to divide up into sections, one on medicine and another on surgery and obstetrics. The discussions, both in the general meeting and in the sections, were more than usually varied and interesting. None of the papers were passed over without a satisfactory discussion, and much information of value to the members was elicited. The interest in this young and vigorous Association seems to be increasing yearly. The wisdom of the departure from the former method of preparing reports on medicine, surgery and obstetrics, which were usually taken as read, was well seen in the admirable papers read by the chairmen of the different departments, and the very interesting discussions which followed. We would still further suggest that, inasmuch as it is now necessary to form the Association into sections, that the chairmen of the sections should be elected at the same time as the other officers of the Association, so that the Association may have the benefit of a carefully prepared address in each department at the opening of the sessions. We trust this matter will not be overlooked at the next meeting of the Association. We are also pleased to announce that the next meeting will be held in Toronto. This is, undoubtedly, the most central place in which to hold the meetings. Owing to the numerous railway lines, this city is within easy reach of the greatest number of members, and adding to these the large contingent in the city itself, there is always certain to be a large attendance. Without in any way desiring to speak slightingly of the cities in which the last two meetings have been held, we believe that it would be greatly in the interest of the Association if all the meetings were held in Toronto. The choice of Dr. Tye as President of the Association was a well-deserved compliment to an earnest worker and a zealous and worthy member of the Association. The Association has been thus far fortunate in the choice of its leading officers, and so long as such worthy men fill these honorable positions, we can confidently predict for it a grand future.

CANADA MEDICAL ASSOCIATION. — It will be remembered that it was decided at the last meeting of the Association to meet this year in Winnipeg. Owing however to the outbreak in the North-West, and the disturbed state of things generally, our brethren in Winnipeg have reluctantly decided to forego the honor of entertaining the Association this year. In consequence of this decision, and by the kind and pressing invitation of our worthy confrères in Chatham, Ont., the Association will meet there on the 2nd and 3rd of September, under the presidency of Dr. Osler. We confidently bespeak a large attendance, and can promise the members of the Association a right hearty welcome from our friends in Chatham.

CHLORAL HYDRATE IN EPILEPSY.—This valuable remedy is well known to the medical profession, but it may not be so generally known as it ought to be that it is sometimes of invaluable service in arresting epileptic fits, especially that form known as the status epilepticus. We have recently had some experience of its use in a case where all other remedies had failed, including inhalation of ether, chloroform, and amyl nitrite. A twenty grain dose immediately put a stop to the frequently-recurring attacks, and the patient made a good recovery from the seizure.

General Grant's Case.—Latest reports in regard to the condition of Gen. Grant, would seem to indicate an improvement, but there is no evidence that the case is not hopeless. General Grant is able from his past military experience "to put himself in the place" of his medical attendants to good purpose. His reported remark to his physicians savors of true wisdom: "The doctors outside I am informed, are writing about my case and talking about it, and some of them seem to think they know more about it than you gentlemen do; but it is like a time of war, when the men at home think they know more about it, and how to do it, than the generals who are in the field fighting."

Uric Acid Calculus of Enormous Size.—The *Lancet* for May 2nd, 1885, gives the following particulars of one of the most remarkable calculi that the records of surgery furnish. It was removed by the high operation by Sir Henry Thompson, from a man aged sixty-two. The stone was of an oval form, of pure uric acid without any phosphatic incrustation whatever. It weighed 14 oz. avoirdupois (405 grammes), and measured 4½ in. long, 3¼ in. wide, and 2⅛ in. thick. The operation was rapid, and performed without difficulty, and the patient's present condition is unusually good and promising.

Peptic Salt.—Dr. Prosser James describes, in the *Brit. Med. Journal* for May 16, 1885, a preparation of pepsin and chloride of sodium, which he calls "peptic salt," to be used as a condiment. The pepsin and salt are combined in such a way as to form a pepto-chloride, which prevents decomposition. He says: It may be ordered in prescriptions, if prefered, as sal-pepticus, or as pepto-chloride of sodium. Ten grains of the peptic salt will dissolve nearly 200 grains of hard boiled albumen, or two ounces of lean cooked meat. It may take the place of table-salt in the dyspeptic's dietary.

Nitrite of Amyl in Gout.—A very important question has been recently raised by Dr. A. McDonald, of Liverpool, in the *Brit. Med. Journal*, regarding the elimination of uric acid by nitrite of amyl. He noticed that on several occasions the acidity of the urine was markedly increased after the administration of nitrite of amyl, and a deposit of uric acid crystals took place in the urine. It was given in a case of puerperal eclampsia, in gout, and also by way of experiment, and in all the result was the same. The drug was given by inhalation, in four minim doses, every two hours.

Buried Catgut Sutures.—In the *Brit. Med. Jour.*, May 2nd, 1885, will be found a paper by Mr. Kelly in which he advocates "buried sutures" in wounds, that is, suturing separately periosteum to periosteum, muscle to muscle, nerve to nerve, fascia to fascia, skin to skin, etc. The advantages claimed are that drainage is not then required, no spaces or pockets are left where blood or serum can collect, and that cicatrization is rapid, complete and perfect. He refers to a number of operations in all of which he says "the results have been all that sanguine hopes could expect."

Whooping Cough.—The following has been found of great service in the treatment of this affection, especially to prevent the night spasms.

℞	Pot. bromidi	ʒ j
	Chloral hydrati	℈ ij
	Tr. belladonnæ	ʒ ss
	Syr. Aurantii	℥ j
	Aq. Cinnan	ad ʒ iij—M.

Sig.—A teaspoonful at bed time for a child one year old and increase according to age.

Use of the Membranes in Labor.—In an article in the *Med. Jour. and Examiner*, Dr. Byford of Chicago, makes a strong plea for non-interference with the membranes during labor, or until they protrude through the vulva. The presence of the bag of waters he maintains favors gradual dilatation, serves to protect the parts from laceration, and prevents irregular contraction of the uterus. He regards it as strange that obstetric science should teach the deliberate breaking up of the simple process of nature and substitute an unnatural and artificial one.

Mustard Sponge.—The latest method of applying a mustard poultice is by means of a sponge. The plaster is prepared in the usual way, the sponge is dipped into it, then wrapped in a soft handkerchief, and applied to the part. By simply warming the sponge again and moistening it afresh, it may be reapplied, the strength being perfectly preserved.

London Medical Society.—The London

Medical Society has been recently reorganized, and the following officers have been elected:—Dr. Beemer, President; Dr. Waugh, Vice-President; Dr. Payne, Secretary-Treasurer. Since the reorganization the attendance has been very good, and some very interesting and instructive papers read and discussed.

APPOINTMENTS.—Dr. Robert L. McDonnell has been appointed physician to the Montreal General Hospital vice Dr. Osler; Drs. Blackader and F. W. Campbell, assistant physicians; Dr. Jas. Bell, assistant surgeon; Dr. W. Gardner, gynecologist, and Dr. Major, laryngologist. Dr. M. McD. Seymour has been appointed surgeon and Dr. F. S. Keele assistant surgeon, of the Winnipeg Battalion of Infantry.

W. R. Warner & Co., of Philadelphia, have recevied the first premium at the World's Exposition, New Orleans, for great uniformity and solubility for their sugar-coated pills This is the ninth world's fair prize which attests to their excellence.

The epidemic which has prevailed so extensively in and around Plymouth, Pennsylvania, and which was not at first fully understood, is now said by competent observers to be typhoid fever.

Books and Pamphlets.

THE CURABILITY AND TREATMENT OF PULMONARY PHTHISIS, by S. Jaccoud, Paris. New York: D. Appleton & Co. Toronto: Williamson & Co.

The title of this book is certainly very attractive. The practitioner or student who reads of the curability of intermittent fever by quinine, certain skin affections by arsenic, gout by colchicum, syphilis by mercurials, or hooping-cough by resorcine, may be led to expect that he will find in Jaccoud's treatise on pulmonary phthisis a therapeutic pearl of incalculable value in the control of a malady which has hitherto resisted all the weapons of the pharmaceutic armoury. He will therefore read the book with very sanguine expectations, but when he has reached the end of it he may wonder how it has been that the cures related have fallen very far short of his fond anticipations. We are told that "exceptions prove the rule," but this does not signify that they constitute the rule. That Jaccoud's treatment of pulmonary phthisis has been, in his hands, *exceptionally* successful, it would be very indecorous to deny; yet when the reader summarizes results, he will most probably find that of the entire category of the cases of this disease, the percentage of cures, even including the shadowy class designated "relative,"—that is, temporary—is mournfully small. The author distinguishes three "varieties of phthisis:—the hereditary, the innate and the acquired form." "Of these," he tells us, "the hereditary form, from the mere fact of its being hereditary, offers the least prospect of recovery." It probably consists with the experience of the majority of practitioners, that this form represents a very large per centage of the whole number, and we fear it has very seldom been the good fortune of any physician to secure the cure of an hereditary case; and if so, the field for the achievement of success must be but limited—far too limited, indeed, to warrant the use of the term "*curability*," unless in a mournfully restricted signification. The term "*innate*," in contraposition with "*hereditary*," seems to us rather inappropriate. Innate literally is equivalent to inborn, ingenerate, inherent, not adventitious. Are not all hereditary diseases such? But it is right to allow the author to speak for himself, which he does in the following words: "Innate phthisis, which must not be confused, as I have already said, with the hereditary form, is observed in the descendants of those who, though not tubercular, are weakened by scrofula, cachectic diabetes, alcoholism, or simply by bad hygienic conditions; besides these causes the innate form may also be due to consanguineous marriages." Now when we shall have added this category of cases to that of the hereditary form, we fear the margin left to curability will be so narrow and shadowy as almost to escape gratifying observance. The author very frankly tells us that we are not to look for great success in this form. "Thus," he writes, "in the innate form there is a possibility, a *chance*, which removes from it the character of absolute incurability, which we were *bound to admit* in hereditary phthisis, when this diathesis was once realised." (The italics are ours.)

Now, as to two, at least, of Jaccoud's factors of innate phthisis,—"alcoholism" and "consanguineous marriages"—we are very much inclined to doubt their specific efficiency, when they are not allied to hereditary predisposition. Alcoholism,

no doubt, is occasionally the precursor of phthisis, but it is well known that the desire for alcoholic drinks is often the result, not the cause, of the organic evil; besides, the great majority of drunkards die of other diseases; and as to "consanguineous marriages," if the two parties to the contract are of well-established physical soundness their offspring will have a very fair chance of escaping, not alone pulmonary phthisis, but also any other hereditary ailment.

Jaccoud's third variety of phthisis are those, he informs us, "in which the pulmonary tuberculosis, being spontaneous and independent of other diseases, could only be due to general debility, to that insufficient or improper nutrition which is the basis of all forms of phthisis." He calls these cases the first group. He constitutes a second group in which he places "those cases in which the pulmonary disease is connected with a constitutional affection, either past or present, and to the existence of which it may be rationally imputed."

As regards the spontaneity and independence of Jaccoud's "acquired phthisis," we had better defer criticism until more is known of the bacillus of Koch. Still, it would be a pity to bereave the eminent French clinicist of any part of the small residue of that field of "curability" to which his endeavour has reduced his right of possession. His book well deserves attentive study, for it contains much that must be found of real practical value. Had it come from the pen of a less able and eminent author we might have bestowed less notice on it. Youthful practitioners are but too prone to indulge in over sanguine expectations, when they light upon any work bearing the prestige of high authority; and when they realize a succession of practical disappointments, a spirit of medicinal skepticism is likely to be engendered, which may ultimately prove pernicious to themselves and harmful to their patients. Do not give up the ship, but see to your ballast, and do not indulge in studding sails and sky-rakes, in a perilous sea. Be warned by the wrecks of other navigators, rather than learn the dangerous sea line by your own calamitous temerity.

WASTING DISEASES OF INFANCY AND CHILDHOOD, by Eustace Smith, M.D., London. Wood's Library, April, 1885.

This work will be read with pleasure and profit by every earnest practitioner of medicine. When we consider how large a proportion of all medical practice is presented in the diseases of childhood, we cannot but welcome any valuable contribution to so important a subject. The present issue is a reproduction of the 4th English edition. If we should single out any particular chapter of the book as of paramount value, it would be that one in which the author treats of "inherited syphilis," with which we find but one fault,—its brevity. But it is a *multum in parvo*. General practitioners in this country, but especially those residing in rural districts, may but seldom be confronted by inherited syphilis. This cannot be any reason for their avoidance of its study; rather indeed the very contrary, for exceptional cases are to be met with in all communities, and those to whom they are more familiar well know how puzzling they are, and how eminently important is their clear diagnosis. The practitioner must not deceive himself by expecting frank, much less, spontaneous, information from parents. In nine instances out of ten the soft impeachment will be repudiated, and not seldom disastrously resented—disastrously alike to the doctor and his innocent patient.

THE LAND OF ROBERT BURNS, AND OTHER PEN AND INK PORTRAITS. By. J. Campbell, M.D., L.R.C.P., Edin., Seaforth, Ont. *Sun* Printing Office, Seaforth. Price, 75 cents.

We are glad to welcome this interesting work by our talented friend Dr. Campbell, of Seaforth, which we have perused with much satisfaction. We would especially note the chapter on the defence of Burns, the article on Sir Walter Scott, and also the reference to Knox and the Covenanters. The work consists in a series of letters written to the Seaforth *Sun* during a holiday trip to Scotland, a few years ago. These are now collected in the volume before us, to which has been added the valedictory address, delivered by the author on his graduation in McGill College, in 1869. The work is both pleasing and instructive, and cannot fail to interest a large number of readers. We congratulate our worthy confrère upon his success in the literary arena, and trust that the work will meet with a large sale.

ON MALIGNANT ENDOCARDITIS.—The Gulstonian Lectures delivered at the Royal College of Physicians, London, by Wm. Osler, M.D., M.R.C.P., Prof. Clin. Medicine, University of Pennsylvania. Reprinted from the *Medical News*. Philadelphia: Lea Bros. & Co.

A HAND-BOOK OF PATHOLOGICAL ANATOMY AND HISTOLOGY, by Francis Delafield, M.D., and T. Mitchell Prudden, M.D., of New York. Second edition. New York: Wm. Wood & Co.

The scope of the work in the present edition has been much extended and will be found to supply all the needs of the student or practitioner. It comprises instruction in the methods of making post mortem examinations, preparing tissues for microscopical examination, examining bacteria, etc. It contains a description of tumors, and also lesions in different parts of the body the result of disease, violence, or poisoning, and the like. The text is well illustrated, and the work on the whole one to be highly commended, and a valuable addition to the literature of the subject.

THE PRINCIPLES AND PRACTICE OF GYNÆCOLOGY, by Thos. Addis Emmet, M.D., LL.D., Surgeon to the Woman's Hospital, New York. Third edition. Philadelphia: H. C. Lea's Son & Co. Toronto: Williamson & Co.

The edition of this most excellent work now before us has been thoroughly revised by the author, and is illustrated by one hundred and fifty illustrations. The work is essentially a clinical digest, and includes the results of the author's experience. It also aims to represent the present state of gynæcological science and art. The author does not favor intra-uterine medication, and regards the different forms of pelvic inflammation outside of the uterus as constituting the chief factor in the diseases of women. The book is a welcome addition to the literature on this interesting and important branch of medicine.

AMPUTATIONS OF THE EXTREMITIES AND THEIR COMPLICATIONS, by B. A. Watson, A.M., M.D., Surgeon to the Jersey City Hospital. Illustrated by 200 engravings. Philadelphia: P. Blakiston, Son & Co. Toronto: Hart & Co.

The author of this new work is a thorough disciple of Lister, to whom the book is dedicated. The scope of the work is much broader than might be inferred from the title, inasmuch as the author deals with all possible complications of amputation wounds. A number of original wood-cuts have been introduced, but the majority are selected from the standard works on surgery, etc., both home and foreign. One important subject is treated of which is rarely found in surgical works, viz., the formation of desirable stumps for prothetic apparatus, the point at which amputation ought to be made, and the selection and application of artificial limbs. We commend the work to the attention of our readers.

A MANUAL OF THE PRACTICE OF SURGERY, by Thos. Bryant, F.R.C.S. Eng., Surgeon and Lecturer on Surgery at Guy's Hospital, with 727 illustrations. Fourth edition. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The two volumes of the English edition have been consolidated into one in the American reprint. This makes the work much more convenient for reference. As it has been recently revised by the author, it has been reprinted without any alteration. No words are needed from us in praise of the work, for both it and the author are favorably known to the profession in this country. The work fully and fairly represents the present status of British surgery, and as such we commend it to the attention of our readers.

A TREATISE ON THE SCIENCE AND PRACTICE OF MIDWIFERY, by W. S. Playfair, M.D., F.R.C.P., Prof. of Obstetrics in King's College, London. Fourth American from the fifth English edition, with notes and additions by R. P. Harris, M.D., with two plates and 200 illustrations. Philadelphia: Lea Bros. & Co. Toronto: Vannevar & Co.

This work is already well known to the profession as an excellent epitome of the science and practice of midwifery, and we gladly welcome the new edition. The work has undergone a careful revision at the hands of the author and his assistants, and the chapter on Conception and Generation has been re-written, so as to incorporate the most recent advances in Embryology. Several new illustrations have been added, and the work will be found a trustworthy guide in the anxieties and emergencies of obstetric practice.

Births, Marriages and Deaths.

In Montreal on the 1st ult, Dr. P. E. Picault aged 76 years. Also Dr. Jos. Leman, aged 56 years.

In Kingston on the 19th ult., Tina Laura Stirling, beloved wife of Dr. K. N. Fenwick. aged 26 years.

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Original Communications.

DIPHTHERIA.*

BY G. A. TYE, M.D., CHATHAM, ONT.

No subject can be presented to practical physicians that possesses a greater interest than diphtheria—a disease as ancient as history itself, and as widely spread as the human race. It stays not its ravages for country nor climate; it ruthlessly invades alike the hut of the peasant and the palace of the prince; it is not ashamed to claim its victims in the house of poverty, nor fears to enter the home of luxury. Many here to-day have had the circle of their own fireside broken, and every one here has felt his utter weakness when the home of his friends was desolated in spite of all his art, and to-day we unite our forces to meet a common foe.

We possess two means—*prevention* and *cure*—which enable us to lessen its ravages. Our greatest power at present lies in the former. It is a great satisfaction that at last we have a system of State medicine established in Ontario, and that legislative enactments now guard the birthright of every subject's health. Such legislation marks an advance in true civilization. The country owes much to the Ontario Board of Health for its energy, intelligence, and thoroughness in carrying out the Act. The people of Ontario are being rapidly educated in sanitary matters, and there are fair prospects that the prevalence of this disease, as well as many others, will be soon limited.

The report of the Registrar-General shows that it ranks high amongst the fatal diseases of this Province. For the year 1876 he reports a large increase in the number of deaths. In 1874 the deaths were not sufficiently numerous to be placed in the list of the ten highest causes of death, but in 1876 it stands third. Many deaths really due to diphtheria are returned as croup; but the death rate from croup also increased in the same year, showing that they were probably due to one cause. In 1877 it stood fifth; 1878, fourth; 1879, sixth; 1880, fifth; 1881, fourth; 1882, fifth, in which year there were 1,239 deaths from this cause alone.

The predisposing causes are telluric, meteorological and individual. Amongst the former are low, damp situations. Houses are placed close to the ground, with no provision for currents of air to pass beneath them to dry the soil or expel noxious vapours. Houses too closely surrounded with plants, shrubbery, or trees, are favourable to the development of low organisms. River flats, sites of old saw mills where there is much decomposing sawdust, seem to be prejudicial. I have observed several cases apparently due to these causes—at least no other could be found. I have notes of nine cases observed in the autumn of 1884, which occurred within two weeks in two adjoining blocks of small tenement houses, placed close upon the flat, damp, undrained ground. Dr. Ryall, Medical Health Officer of Hamilton, reports to the Board of Health (in April last) of that city, the condition of the premises in which diphtheria was found. The description is so vivid and terse that I produce it: "The results of the examination of the affected districts revealed cellars dirty and damp, smelling strongly of sewer gas, vegetables stored in cellars decomposing and smelling badly, kitchen sinks and baths untrapped and unventilated, being connected either with sewer or water-closet, or bad smells in back yards, defective pan water-closets, soft-water cisterns under the kitchen floor, well-water used which received drainage from the surface manure heaps. A few cases occurred where the premises were in good order, but the surroundings were bad." The germ of diphtheria, whatever that may be, always finds in such conditions a suitable nidus for development—breeding spots where one germ generates many. All these causes are in the preventible list, and with the aid of the physician the people can remove them.

Meteorological conditions of a certain kind are strongly predisposing. The Michigan State Board of Health finds that diphtheria is increased by—increased daily temperature above the average for that period of the year, increase of humidity, increase of cloudiness, excess of winds, excess of ozone, high barometric pressure. Our own health

*Read before Ont. Med. Association, London, June, 1885.

reports establish the fact that the disease is most prevalent in November and December, when many of these conditions exist. During this period there are high barometic pressure, magnetic displays, and an electrical condition of the air producing nascent oxygen and ozone. The experiments of B. W. Richardson show that these gases are irritating to the respiratory passages, hence we find an excess in sore throats, and a corresponding increase in diphtheria. We must conclude from these premises that sore throat is a favourable locality for the reception of the diphtheria germ. The throats of children are very susceptible to atmospheric changes, and consequently age is a predisposing cause. The greatest mortality occurs from two to five years of age. The Registrar-General's Report for 1879 states that, of 574 deaths, 283—or about one-half—were under five years ; 184 between five and ten. In 1881, 72 per cent. were under sixteen ; in 1882 there were 1,239 deaths, 83 per cent. were under fifteen. The *exciting* cause of this disease is probably a germ from some former case. Bacterial pathology has not yet clearly established its nature. The natural history of these germs teaches us that they thrive best where there is moisture and decomposition of organic matter, and continue to produce their kind so long as favorable soil is present, and that those already formed may linger long in a locality after the production has ceased.

Dr. Bryce in the Health Report for Ontario, says there does not appear in the whole catalogue of disease one which is so persistently endemic in a locality when once introduced. What are the modes of communication ? It is communicated by the direct passage of morbid material from a diseased throat to one previously healthy. The history of tracheotomy presents some lamentable illustrations of this fact. It may be communicated by the inhalation of germs existing in an insanitary locality, although no case of the disease then exists there. It is communicated by germs wafted in the air, and that for a considerable distance ; and they produce the disease, more especially when a predisposition exists, so that many suffer whose sanitary surroundings are apparently perfect. The clean, as well as the unclean, may be obliged to share the calamity. I shall confirm these propositions by a few cases. A medical man reports to the Provincial Board that the mother of a large family laid out the body of a little girl dead of diphtheria. In a few days four of her children were down with it. The pall-bearers were boys. One of them took it home, and seven of that family were taken ill.

Last December I saw a boy, aged fourteen, then ill for five days. His mother saw membrane in the throat. Croupy symptoms were strongly marked. It was a serious case. I found that three weeks previously he passed the night at the house of an uncle, and slept in a bed in which a child had recently died of diphtheria. Dr. Holmes, of Chatham, related a case which seems to show that it may be carried in clothing. A gentleman called at a house on business, and was obliged to remain there some hours. The disease existed in this house. He went to his own home some miles distant. No cases were near his own residence, yet both wife and child took the disease, and the child died.

Dr. Mullin, of Hamilton, tells of a family under his care ; four members suffered ; the first a schoolboy ; the early indications appeared Nov. 6 ; the other children were sent from home at once, and the patient was convalescent on the 13th. The other children were brought home on the 20th, and efforts made to keep the convalescent one isolated ; however, on the 30th another was seized ; Dec. 1st another, and on the 6th the third. He says the occurrence in the last three seems to him fairly attributable to contagion from the first.

During the winter of 1884, I observed a number of cases in one neighbourhood, which seemed to prove its passage in the air. In a tenement house, standing alone in a filthy state, two children died of diphtheria ; across the street, and a few rods eastward, was a row of houses, all situated on high, dry ground, fair water and families in good circumstances. In a few weeks after the deaths in the tenement house, it appeared in this row, which was in the direct course of prevalent winds ; two children in one house, five in the next, and four cases in the third house, in all 11 cases occurred in this row of houses ; the two in the first house recovered ; one of the five in the second house died of heart paralysis some days after apparent convalescence, another had a narrow escape ; in the third house one died ; a visitor had contracted tonsillitis while boating on a damp evening ; she died from stenosis of the larynx. Four weeks later five cases oc-

curred in an adjoining block, in my care; another case close by attended by another physician; some weeks later, in a house close to the original outbreak, but on an opposite side, two children died in one family, altogether 19 cases and 6 deaths in a radius of about 20 rods. Our Board of Health was not yet organized; had there been means to have thoroughly cleansed house No. 1, I believe disease and death would have been prevented.

Prophylaxis is a most essential part of the treatment, for more can be saved by prevention than by cure. It must be confessed that our treatment is not yet what we may hope for. The prophylactic measures can be inferred from the etiology already stated. Let the unaffected ones of a family be isolated at once, if possible, in another house, and in a different locality, as high and dry as can be secured, and let the quarantine be prolonged. All exposure to cold winds must be avoided. Keep throats of sound children disinfected with proper applications. I am sure this will prevent some cases. Every case of sore throat should be promptly treated. Rooms occupied should be large, well ventilated, and kept at an even temperature. The vapour of turpentine, tar, or sulphurous acid are probably useful, and are very well tolerated. Every infected locality should be visited by the authorities and completely disinfected to prevent the spread of the disease.

The question of the identity of croup and diphtheria has been discussed for some time without reaching a definite conclusion. The views of Lewis Smith in a recent article are correct, that membranous croup is not a disease of itself, but an outcome of other diseases or conditions, and states them in the order of frequency: 1. diphtheria; 2. cold; 3. measles; 4. pertussis; 5. scarlatina; 6. typhoid; 7. irritating inhalations. He says that in all instances the morbid anatomy, clinical history and required treatment of the croupy state are nearly identical; and that attempts to differentiate them are futile. This puts the identity as regards treatment too strong, for in diphtheritic croup the system's condition is more adynamic than in croup from cold. In croup from other causes there is a sthenic condition, stenosis is the principal difficulty, and calomel can be pushed farther or jaborandi used.

Jaborandi was tried extensively in the terrible epidemic of diphtheria in Russia a few years ago in the croup cases, upon the theory that the abundant secretion produced would so influence the condition of the parts as to prevent the formation of membrane or dislodge that already formed. The statistics do not favour its use in diphtheritic croup from its depressing tendencies. In cases of croup due to cold I have found it a powerful agent for good, and children tolerate this drug to a remarkable degree.

The *treatment* of this disease has a superlative interest. It is strange how many specifics there are—how many there are that find sure cures and safe cures. There are medical men who say they have never lost a case. Happy is the man who can so flatter himself. The local treatment is secondary in importance to the general treatment. The throat is now no longer injured by caustics, acids and rough swabs, which would produce a sore throat where none already existed. The throat should be kept as clean as possible with frequent gargles of hot water, which lessens the hyperæmia. Solutions of chlorate of potash are grateful. A soft camel's hair brush should always be used to make applications. There are many applications so equally good that it makes little difference which we employ. Sulphurous acid and glycerine, with the addition of thymol, is effectual and pleasant. Oil of eucalyptus and liquid petroleum make another good topical remedy. Lactic or acetic acid with glycerine I have found useful. The atomizer is an excellent instrument to make applications to the throat by the mouth, or through the nose, where the patient's age permits. Much harm can be done by using violence to dress the throat. Solutions that permit of being swallowed are better than forcible swabbings. Formerly membranes were eagerly detached, leaving a raw, bloody surface, upon which a new membrane rapidly forms, often in 24 hours. The membranes should be well cleansed and disinfected, and allowed to drop off when ripe for separation, after which they rarely return. Loose, hanging portions can be removed with scissors. Rossback, of Germany, after four years' trial, speaks favorably of the vegetable digestive papayotin. It acts well in an acid or an alkaline medicine. Dr. Lewis Smith mixes one drachm of Fairchild's extractum pancreatis with three of sod. bicarb, then adds one teaspoonful of this to six of water and pencils the fauces, and uses trypsin with the atomizer for mem-

branes in the larynx. A discussion of this subject at the last meeting of the American Medical Association confirmed the use of tried remedies, but nothing new of value was introduced.

The longer I treat diphtheria the more am I convinced of the power of tincture of iron, alcohol, quinine, and chlorate of potash, but the first mentioned is superior to all. These articles are all eminently safe, whether the tendency to death be from asthenia or from asphyxia; but the best effects of iron are seen only when administered in very large doses. Dr. Jacobi, in the *American System of Medicine*, recommends from 5 to 15 minims properly diluted every fifteen minutes or half hour, and I am sure from my own experience that this is valuable teaching. There is certainly a tolerance of the drug in this disease.

Alcohol given early and freely stands next to iron. Austin Flint, in an admirable article on Medicinal and non-Medicinal Therapeutics, thus speaks of alcohol in this and kindred affections: If alcohol be useful as a material for combustion within the body, it is indicated in the condition of fever, prior to the indication for its employment to sustain the failing powers of life. The object from this point of view is to forestall these indications and prevent the asthenia. It is evident that employed with a view to test fairly its value as an antiseptic or parasiticide, or as an antidote, it is important that it should be employed early, continuously, and in as large quantities as it may be tolerated.

Chlorate of potash is a well established remedy, but given in very large quantities will produce nephritis and albuminuria. Quinine in tonic doses is an excellent adjunct, but its bitter taste makes it difficult to administer to young children. When croupy symptoms appear there is still a possibility of arresting the further progress of the membrane by the increased dose of iron and alcohol. For many years I have found excellent results from the frequent administration of small doses of calomel, one gr. per hour, and free inunction of the neck with oleate of mercury. I know no remedy equally potent. The inhalation of moisture, in the form of vapour, is beyond doubt of considerable value. The atomizer is the best instrument for producing the vapour. I have tried to use ice, but my patients would never tolerate it long enough to judge of its merits.

When the stenosis continues to increase in spite of remedies, no time must be lost if the trachea is to be opened; for if there be any hope from the operation it is when done comparatively early. The results are not encouraging. The benefit of this operation, so manifest in croup from other causes, is not found in diphtheria, for it does not check the disease. Dr. Holmes, of Chatham, informs me that he has operated three times with a fatal issue in every case, but he would advocate the operation for euthanasia.

The albumen of this disease is rarely due to a nephritis, but to congestion of the kidneys, for it rarely produces dropsy or uræmia, and recovery is rapid after the cessation of the cause. The dyspnœa produces general engorgement which the kidneys must share; or the vagus being effected, the heart is weakened, and the congestion is due to this cause. The paralysis of diphtheria is fortunately not very frequent; some epidemics are much more marked than others by its appearance, and unless it involves the heart, or the paralysis is general, there is a strong tendency to spontaneous recovery. I have used faradism, but cannot say that it has hastened recovery. There is some evidence that galvanism has a beneficial influence. Professor Thacher, of Yale, has made some careful observations on the effects of massage, faradism and galvanism. There was a positive gain from galvanism, no effect from faradism, while massage seemed to lessen the power.

PLASTER SPLINTS IN THE TREATMENT OF FRACTURES.*

BY N. A. POWELL, M.D., EDGAR, ONT.

MR. PRESIDENT,—When, a year ago, I proposed that instead of the annual reports containing digests of the progress in each department of medical science, such as had been presented to you, discussion should be arranged for, I did so with the conviction that the existing facilities for the rapid transmission of medical events to every reading member of the profession render such reports no longer necessary. In offering a resolution which you saw fit to adopt, I had no thought that like Haman of old I should be the first to appear on the gallows which I had moved to erect for another.

*Read before the Ontario Med. Association, June, 1885.

However, being here, in hope that the interest attached to the subject may redeem my faulty presentation of it, I ask your attention to the use of plaster splints and bandages in the treatment of fracture. Of all the materials which may be used to form dressings, soft when applied but rapidly becoming hard and unyielding, this is the best and the best is just good enough till we can improve upon it. Plaster of Paris or gypsum, used in surgical practice by the Arabs in the last century is perhaps not better than when first introduced, but the methods of its use have undergone a process of evolution and are now so perfect as to merit the close attention of each one of us. A clear distinction must be made between such splints, and bandages. By the first we mean supports moulded to a part only of the circumference of a limb or other portion of the body, while by the last we mean dressings which completely encircle the extremity requiring fixation. The two forms of course may approach each other till they meet and merge. As a class the splints are removable at will while the bandages are not so. This distinction is important since the risks belong almost entirely to the bandages, while the benefits can as a rule be obtained by one form or another of plastic splints. Believing that in regard to comfort and security from displacement they are, in the treatment of certain selected fractures better than any other means at our command, I have raised the question of their use in the hope that through you, and with your aid, it may be possible to reach and impress a number of our brethren who either do not use these appliances at all, or do not use them in ways most convenient for themselves and most helpful to their patients. It is to be expected that the discussion evoked will be of greater value than the paper read, since it will become the means of recording a wider experience and reflecting the ideas of others from different standpoints. Let me remind you that your indication of points upon which we differ may be productive of more good than a silent reception of whatever is advanced. With the object of economizing time I shall spare you historical details, shall speak perhaps somewhat dogmatically, and shall give you conclusions rather than the reasons which have led me to them. I shall seek less for originality than for practical utility, and whether speaking or listening shall not forget the saying of Paget, that each one of us has something which he may teach, and much more which he may learn. If upon some points I enter into detail, it will be because of a belief that in attention to these minor matters lies all the difference between danger and safety, between success and failure. I base what I have to say on what I learned as a student from my old and honored teacher Dr. F. H. Hamilton, of N.Y., on ten years constant use of gypsum dressings, on such study as I have been able to give to the literature of the subject, and on what I have from time to time seen in the hospitals of New York, Boston, and Philadelphia. I trust that some who hear me and who have had trans-Atlantic experience will give us the results of their more extended observation.

Materials—Only the finest and freshest dental plaster should be used. The common sort applied as a hard-finishing by plasterers is not fit for surgical purposes and its use invites failure. The office supply should be kept in tins the covers of which screw down air tight upon rubber rings. Cosmoline tins, of five lbs. size, may be obtained at any drug store and answer the purpose perfectly. In preparing the mixture of plaster and water known as "cream" the solid should be added to the fluid and not the fluid to the solid. About an equal bulk of each makes the proper proportion. Common salt or the sulphates of soda or potassium or alum can be added to the water to hasten the setting of the plaster, while a weak solution of glue or gelatine, if used, would delay such crystallization. Cloth sufficiently porous to allow the plaster to set in its meshes and not simply on its surface is the other essential. The experiments of Drs. Marcy and Nelson proved that the lightest and strongest of plaster dressings were those made from cotton cloth such as is used for printing upon. This, free from fatty matters or starch finish is only to be obtained from the bleacheries. It differs from cheese cloth as cotton batting differs from absorbent cotton. Cylinders made with it and plaster, crushed down only at a pressure of 110 lbs. while those of equal weight and thickness made from crinoline crushed at 60 lbs., and from cheese cloth at 10 lbs. Acting on this hint I have been in the habit of using cheese cloth for plaster bandages, first preparing it by boiling in an alkaline solution and then in clear water to remove the alkali. I am satisfied that the gain in strength is sufficient to pay for the trouble, but regret that I cannot as yet

make a more accurate statement. The size to be preferred is a width of three inches and a length of three yards. Into the meshes of such bandage material the plaster is to be rubbed by hand, and then each roller is to be wrapped in paper if it is not to be used at once. They can be best kept in the tins covered by a layer of plaster. From unsized cheese cloth, from bleached Canton flannel, from cheap, that is cotton-containing flannel, or from old blanket, all other plaster dressings may be made. As a protection for osseous prominences and as a lining generally for plastic dressings, unbroken rolls of the finest cotton batting, white cotton wadding in roller form or blanket flannel will be required. A solution of the bicarbonate of soda in water or the white of an egg will remove the unpleasant feeling left in the hands after using plaster.

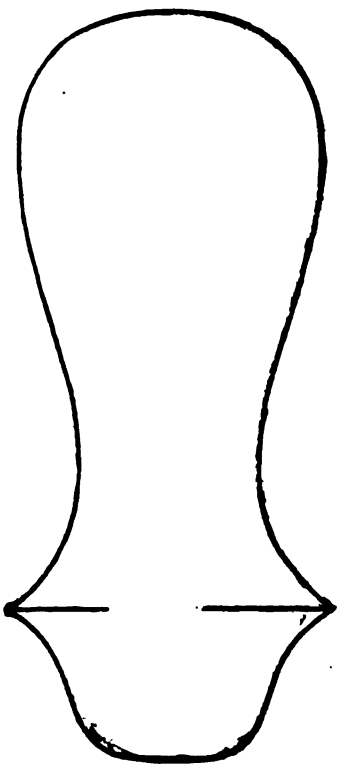
Methods—Upon the principles of the treatment of fractures there is general agreement, but on no subject in surgery do opinions differ more widely than upon the methods by which these should be carried out. In part this is due to the fact that similar good results may be obtained by so great a variety of means. The particular plan employed is of much less importance than the skill and judgment used in its application. A surgeon with strips of wood, padded with moss, and secured by thongs of basswood bark, will succeed, where a mal-adroit backed by a brigade of surgical machinists will fail. Progress of late has been in the direction of simplicity with efficiency, and these are marked characteristics of plaster dressings. The material affords scope for the ingenuity and dexterity of the ablest of surgeons, while on the other hand it may be used in safe and simple ways by any one who will take the trouble to master the *technique* of such dressings. Not to every one is given the ability to invent modifications, as special cases require them, but good methods and correct models are not hard to follow. The plans we shall consider are not the results of any one man's work. Many have labored and we enter into their labors, since that which is of value the profession retains and developes. We may justly claim that

> "All of good the past hath had
> Remains to make our own time glad."

The spiral bandage with plaster in its meshes applied over a leg fracture may be taken as a type of all the uses of the roller. I shall describe somewhat minutely what I hold to be the best manner of its application. The limb, if hairy, is to be oiled, and then it is to be enveloped in a thick layer of cotton batting taken unbroken from a roll. This layer should extend from the toes to the mid-thigh, should meet in the middle line in front and should be held in position by thread wound around the leg. Over this is to be applied with moderate firmness by the figure of 8 turn, and without reverses, a dry cotton roller. This must not be confounded with that relict of the dark ages a "primary bandage." The gauze cloth or crinoline bandages before described are to be next placed two at a time on end in a bowl of warm water. When the bubbles cease to escape they are taken out pressed to expel surplus water, and are applied from the toes up. No one turn should be drawn more snugly than another. If too tight there is danger of strangulation, while if too loose the risk is that co-aptation of the fragments will not be maintained. Each layer as applied should be well rubbed by the hand to expel the air between it and the one next beneath it. From three to six layers will be required. An assistant is to make moderate extension during the application, and for from ten to thirty minutes afterwards. The heel should rest in his right palm, while his left hand is passed around the instep. If seated comfortably, and able to rest his forearm against his knees he will be able to hold the foot at right angles with the limb, prevent rotary displacement by sighting over the great toe and inner margin of the patella and will not become unsteady through muscular fatigue. To bring the toes up after the dressing is completed is dangerous, since it is apt to constrict at the instep. To allow them to drop is to run the risk of having the heel permanently elevated. When the limb is a heavy one, an inch wide stiffener of perforated tin may with advantage be interwoven in the bandage at each side. When the shell has become fairly firm the limb is to be placed upon a moulded pillow on which in from two to four hours it will become sufficiently rigid to stand being suspended. Such an apparel, light, shapely and perfectly fulfilling the indications, is the one I ordinarily employ in the *later* stages of leg fractures. It gives a firmer support than any hinged splint, and its use will materially shorten the period of confinement to bed. An elevated shoe on the sound side will assist the patient to keep the promise exacted from him that

he will not, till allowed, bear weight on the injured limb while moving about on crutches.

In recent fracture I much prefer an apparel that will allow examination from day to day till the consolidation is well advanced. Even after the most perfect reduction I want to *know* and not simply to *hope* that the fragments maintain their proper position, and that the soft parts over them are in good condition. In 1872 I first applied what is known as the Bavarian or book splint. After using it a few times I began to substitute shaped pieces of cheese-cloth saturated in plaster cream and placed between the inner and outer flannels, for the thick usual layer of solid plaster. With this hinged splint I have treated about thirty fractures of the bones of the leg. It is lighter and stronger than the Bavarian, as ordinarily made, and it can be applied with safety when to use a plaster bandage would be malpractice. By placing the limb first on one side and then on the other the halves of the splint can be raised like lids, and the seat of injury examined without risking in the least a disturbance of the process of repair. I show you one of these, but shall not urge its claims upon you since I wish to use the time at my disposal in advocating a still better and more easily applied retentive apparatus. This is one that I first saw at the Boston City Hospital three years ago. It is known as the "plaster posterior splint," and its development is largely due to the skill and ingenuity of Dr. R. A. Kingman, of Boston. This gentleman writes me that the original idea came from Brooklyn, N.Y., and that his connection with it has been in improving its details and demonstrating its utility and practicability. Through his courtesy I am able to show you three photographs of one of these as applied before the Massachusetts Medical Society last year, after the reading of a paper on the subject by Dr. Geo. W. Gay, surgeon to the City Hospital. I show you also a completed splint and a pattern of the shape into which the material for it was cut. One surgeon, well able to judge, considers this to be the most important advance in the treatment of leg fractures within the last fifty years. Another, and with him I certainly agree, thinks that it comes nearer than any other to being an ideal dressing for a broken leg. Unlike the Bavarian it is always open, permitting sufficient examination without disturbing the limb. It is also far easier to apply, and when applied is self-retaining. It may be made in this way: The limb is first bandaged with wadding in roller form, enough being used to protect the bony processes and the tendo-achilles from pressure. A single layer of gauze or crinoline large enough to extend from the toes to above the knee, is to be placed beneath the limb closely wrapped about it and cut so as to completely surround it with the exception of a space about an inch wide on the anterior aspect. This piece serves as a pattern by which the other layers, six or eight in all, are cut. The cloth is to be deeply slashed on each side opposite the point of the heel to allow the foot piece to be brought to



Pattern of "Plaster Posterior Splint."

a right angle without forming clumsy folds. The layers are now to be soaked in plaster cream, placed one upon another, applied to the limb at once and moulded closely and carefully to it. At the sides of the ankle where the angles from the foot piece and the leg piece overlap, I find it gives the neatest result if they are interlocked two at a time. A bandage rapidly applied secures a perfect fit of the splint to the limb and can be removed when the plaster has become firmly set. If no bandage be left on the leg the splint will accommodate itself to

any reasonable amount of swelling. Some cases of Pott's fracture with marked eversion of the foot require more powerful pressure to maintain reduction than this appliance can give. For the cases however to the treatment of which it is adapted it will be found a comfortable and efficient, as well as a light, safe and æsthetic dressing. While I would hesitate to advise the adoption of the spiral bandage as a routine dressing for recent fractures, I feel free to say that its advantages can be secured and its risks avoided by the use of the splint just described. Swelling may not, and in the vast majority of cases will not occur if this be early applied. Such swelling is no more a necessary accompaniment of the repair of a fracture than of the healing of a strictly aseptic wound.

For what fractures is the treatment by gypsum to be recommended? — For those of the lower jaw, in which an inter-dental splint either is not required or is not obtainable. Six layers of cheese-cloth (or two of Canton flannel) cut to the proper size and shape, soaked in plaster cream, moulded to the part, coated when hard with spirit varnish to afford protection from saliva and lined with cotton or Canton flannel, will make an appliance as serviceable as any other. A Barton's bandage will retain it in position. I show you one made in this way. A broken clavicle can be treated in half a score of ways, any one of which would fulfil the indications as well as any application of plaster of Paris with which I am acquainted. The humerus broken in any part may be safely and securely retained with its fragments in normal position by shoulder caps, internal angular splints or some combination of these made rigid by plaster. The internal angular splint is also, in my opinion, the best for fractures at or near the elbow. I show you outlines of the shapes into which cloth may be cut to form these supports, and also have here completed splints. The angular ones have no special advantage over those of similar shape which may be made from softened binders-board. No single fracture of the forearm is as well treated by plaster as by properly padded wooden splints. A plaster bandage seems to me to be the worst of all dressings for those which occur near the carpal end of the radius. It tends to press the bones together and to obliterate or narrow the intervening space. It prevents the frequent examinations so requisite here. It constricts a part which being dependant is apt to swell and it has not even the excuse of adding to the patient's comfort. Just here let me protest against the dangerous doctrine that all may be considered to be progressing favorably if only the fracture gives no pain. The worst results I have ever seen have come from an acceptance of it by those who are using plaster in an unskilled manner. The problem presented by a Colles' fracture is best solved by, first, a perfect reduction and, second, the accurate pressure of a dorsal pad over the lower fragment and a palmar pad over the lower end of the upper one. Such correctly limited pressure is what we cannot get with a plaster bandage, and so I condemn its use here. Under exceptional circumstances a plaster jacket might be advisable over broken ribs, but unilateral strapping with imbricated strips of good moleskin plaster has sufficed in all the cases which I have so far seen. A recent fracture of a thigh bone may be put up by experts in a hospital, where from hour to hour it will be under observation, but under other circumstances this method is not to be commended. The dangers are greater and the results are not proven to be better than by the alternative plans. Drs. St. John, Marcy, Cowling, and Sayre, have urged the adoption of the plaster bandage as a routine dressing for these lesions, but the vast majority of those who, like myself, have fairly and without prejudice tested the plan, have given it up in favor of the two others which have a right to our entire confidence. These are Buck's modification of the weight and pully extension of Hildamers, and the Smith-Hodgens' oblique suspension. A surgeon at the present day who has had shortening or deformity after a thigh fracture to account for to a jury, will be less likely to be mulcted in damages if he can prove that with intelligent and conscientious care he has used one of the above plans, than if he has put his trust and his patient's limb in plaster, or as Rip Van Winkle might, has depended on the long splint of Lister.

My conviction is that continuous and equable extension, indispensable here, is not maintained by the most perfectly applied plaster bandage, still less by any plaster splint. After fairly firm consolidation I do not object to this form of support, although by it I have seen a knee so stiffened that its patella was fractured in the attempt to regain motion by *Brisment forcé*.

Taking up next the patella I shall only state my

entire approval of the splint made according to the method of the late Dr. J. L. Little, of New York. The oblique strips to fix the patellar fragments, hardening while the fingers of the surgeon hold the parts in apposition, are better than adhesive plaster or anything else of which I have knowledge. Dr. Little's paper can be found in the *Medical News*, March 29th, 1884. With few exceptions fractures occurring below the knee are better treated by plaster than in any other way whatever! A fracture box, filled with oakum, may be used for a few days if swelling is extensive. If not, a hinged or posterior splint, as described, should be applied, and the limb at once suspended. Any blacksmith can make, for a few dollars, a Salter's cradle, which put together with thumb-nuts is very portable. In mine the limb is supported on strips of bandage, exactly as in Hodgen's thigh splint. The saddle pad required to prevent very oblique fractures of the tibia from becoming compound, or used for the same purpose in connection with the V or Y shaped fractures of the tibia, so well described by Gossulur, can be well applied if a posterior splint has been reinforced by three strips of tin in its substance. Time does not obtain for my discussing at any length the subject of compound fractures, yet it is just in this class that plaster dressings have given the most brilliant results. Fenestrated or bracketed plaster bandages, and antiseptic occlusive or "through drainage" methods have changed the prognosis in these injuries, lessening the number of cases that demand amputation, and reducing to a minimum the septic dangers that are to be feared in an attempt to save the limb.

What risks attend their use? These depend on the selection of unsuitable cases, an improper application of the dressings, or an improper management after application. No solidifying dressing should ever be applied to a recently broken limb if much contusion, swelling or ecchymosis exists, or if there is doubt as to the integrity of the deep vessels of the limb. The toes or fingers should always be left uncovered, and should be watched so that on the least evidence of sluggish circulation the encasing material may be cut down or otherwise loosened. Circular compression and strangulation are most to be dreaded. A plaster case may look well and yet be the cause of deadly danger. It cannot be denied that the bad results following the plan of treatment we are discussing are out of all proportion to the number of cases treated by it. Too frequently the usefulness of the limb and the reputation of the surgeon have been involved in a common ruin. Its intemperate and indiscriminating advocacy by certain men who ride their hobbies with whip and spur, have led to its employment by those not practically familiar with it, and too indolent or careless to become so. Dr. Coskery, for instance, at the last meeting of the Med. and Chir. Soc. of Maryland, stated that "it was highly improper to keep a patient suffering from a simple fracture of the thigh, on his back even for 48 hours. Such treatment would be a justifiable cause for a suit for malpractice. Dr. Sayre in a private letter read at the meeting of the Georgia State Medical Society in '84, said, "I dress *all* fractures simple, compound, comminuted and complicated, immediately after the accident if I can see them before the swelling has occurred . . . and a perfect recovery without deformity is the rule instead of the exception as was formerly the case." Dr. Sayre's statistics, as most of us know, are being constantly, though perhaps unconsciously, moulded to fit his theories. Like a good microscopist, he *can* see anything that he *wants* to see, but it is only just to him to say that he really *does* see more that is commonly overlooked than any other surgeon with whom I have the honor of an acquaintance.

Advantages claimed:

1. The fit being perfect there is little liability to displacement.

2. Support sufficiently firm to prevent displacement is obtained before even the busiest practitioner has to leave his patient. This is not the case with any similar plastic material.

3. Compression is uniform, limiting extravasation and controlling muscular movements.

4. In some form these dressings can almost always be applied at the first visit.

5. The material is always at hand and costs almost nothing.

6. Apparatus made from it can be depended upon not to contract in drying, as those made from other plaster materials do.

7. They are sufficiently porous to permit the escape of the perspiration.

DR. OLIVER WENDELL HOLMES says that a doctor's patients must put their tongues out, and a doctor's wife must keep her tongue in.

RENAL CALCULI.*

BY A. GROVES, M.D., FERGUS, ONT.

In the comparatively brief time allotted to readers of papers before this Association, I propose to discuss the subject of renal calculus, first as to its causes and then briefly indicate the line of treatment I have found most beneficial in my own practice. In order to show that the subject is one of great importance and well worthy the serious consideration of all members of the medical profession, it is only necessary to recollect that forty-seven per cent. of all infants whose kidneys have been examined were found, according to Ebstein, to present evidences of uric acid infarctions, and it is also a well known fact that more than ninety per cent. of all cases of stone in the bladder have originated in a small concretion that had passed down from the kidney.

Several theories have been advanced to account for the formation of renal calculi, such as the catarrhal, the gouty, the diathetic, etc. By those who believe in the purely diathetic origin of calculi it has been argued that there are three diatheses, viz.: the urate, the oxalate and the phosphatic, one of which was the cause of renal stone in any given case. My own opinion is that with some rare exceptions the formation of primary kidney stone depends upon a predisposing cause which may be called the uric acid diathesis, and certain exciting causes incident to the food and surroundings of the individual, together with a precipitating cause without which stone is not deposited. The exciting causes determine the particular variety of calculus which may be found in any given case, but in the absence of the other two factors the exciting causes will not result in calculous deposit.

The mere presence of the diathesis alone will not cause the deposit of stone, for many persons habitually pass large quantities of uric acid without the development of any form of calculus. Ultzman has demonstrated that when the urine is only mildly acid, uric acid is deposited in normal rhombic prisms, but that if the acidity be increased the crystals take the form of elongated, pointed and radiating rods, and that it is precisely these spiny crystals that are found in cases of calculous pyelitis. Dr. Ord shows experimentally that the form in which uric acid is deposited is often determined by the other urinary constituents. Eichorst cites a case where a gentleman invariably passed several uric acid concretions after drinking moderately of wine, and I have had under my care for some time a patient who is regularly attacked with renal colic during pregnancy, but at no other time.

Persons who are exposed to the same influences and who are similarly nourished, always have the same character of kidney infarction. Thus in the fœtus and young infants, whose nourishment and surroundings are measurably the same, none but uric acid infarctions are found, but the conditions as to food and surroundings being changed other forms of deposit take place.

It would appear that dyspepsia has a considerable effect in determining the occurrence of calculous disease, hence those of sedentary habits are oftenest affected. A purely vegetable diet also seems to tend to the production of stone, and it is admitted by almost all authors that malt liquors have the same effect. Although not proven it is highly probable that diet has a considerable influence in the production of calculi. Cheshire, England, is almost exempt and the people live largely on a mixed diet, into which milk enters in no small amount, whilst Norfolk, with a population of between 400,000 and 500,000 has annually as many cases of calculous disease as the whole of Ireland, where milk also enters largely into the food of the people. Mr. Cadge believes that the great prevalence of stone in Norfolk is to be to a great extent accounted for by the inadequate supply of milk and to the universal prevalence of beer drinking. He is also of opinion that the effect of accumulated hereditary predisposition, in other words diathesis, is a factor entering largely into the causation of lithuria.

It is a doubtful question whether or not water containing lime salts favours the production of stone. My own limited experience would tend to support the opinion that water from limestone rocks has a tendency towards the production of renal stone. I have found that in the county of Wellington, along the Grand River, which runs through limestone rocks, calculous affections are comparatively common, so much so indeed that I rarely find myself without one or more patients suffering from calculous disease. I am at a loss to account for this prevalence of such disease on any other

* Read before the Ontario Medical Association, June 3rd, 1885.

hypothesis than that it is connected with the hardness of the water, for the food, clothing, habits of life, climate, etc., do not differ from the people around them. Dr. Roberts points out that a certain district, a suburb of Manchester, has furnished a considerably smaller number of cases of stone since the use of softer water supplied by water-works has taken the place of hard well water, and he gives no other explanation of the falling off in the number of cases.

Professor Gamgee draws attention to the fact that sheep pastured in limestone districts are particularly prone to become the victims of calculus, whilst under other conditions it is a rare affection amongst them.

In Finland, stone is an almost unknown disease, and the water coming mainly from granite mountains is remarkably pure. The Finlanders however are not addicted to excesses of any kind, live active lives and subsist on plain diet into which milk enters to a considerable extent. Estlander believes that the hot vapour baths common amongst them has a marked influence in securing that immunity which is so remarkable.

It would appear that the negro race are rarely affected with calculous disease, American statistics showing a proportion of not more than one to six of the white population. So far as my investigations have gone, I believe a similar immunity is enjoyed by the American Indian. It would appear that in these races the diathesis is less strongly marked, and that they are less exposed to those influences which tend to cause renal deposits, such as drinking strong or malt liquors, indigestion and sedentary habits.

There are renal stones which may be classed as purely accidental, such as those commonly occurring in Egypt, where the nucleus is found to consist of the ova of the Diastoma hæmatobium, also those instances in which blood clot, etc., forms the nucleus. In these cases the formation of stone is secondary, the nucleus being really a foreign body and consequently they ought to be classed separately from those arising idiopathically.

It is a rather remarkable rule, to which there are many exceptions, that only one kidney is affected by calculous deposit in the same patient. The explanation of this peculiarity which I would offer is, that inflammatory or catarrhal attacks probably affect only one kidney at one time as is usual in other double organs such as the lungs, and that even a mild catarrhal attack produces a colloid material in persons predisposed to calculous disease. Rainey has shown by experiment that the presence of colloid matter causes the precipitation in spheroidal masses of crystalline salts, and this is the form in which uric acid nuclei are found. If only one kidney be attacked by the catarrhal inflammation or by congestion, that alone will be the seat of calculus; if both be attacked then stone formation may take place in both kidneys simultaneously. It might be objected to this theory that many victims of renal calculus have never had symptoms of catarrh of the kidney. My reply is that kidney catarrh usually presents no marked symptoms, and might very easily be overlooked, that in fact catarrh of the kidney is an exceedingly common occurrence. It may be caused by a glass or two of beer, by the chilling of the skin in a cold bath, even by purely mental causes as most people have had more or less demonstration of in their own persons. To epitomize, then, I believe that these three factors are necessary for the production of renal calculus. First a special diathesis, secondly certain exciting causes incident to the ingesta and surroundings of the person, and thirdly a catarrhal or inflammatory attack which acts as the direct cause of the deposit.

With reference to the treatment of an attack of renal colic, I may say that the advice commonly given, viz.: to administer belladonna, opium, diluents, etc., and to place the patient in a warm bath, with the application of wet cups or perhaps venesection, is utterly inadequate to relieve the frightful agony experienced during the passage of renal calculus along the ureter. I speak of what I know, having been myself a victim of the trouble in question, when I advise the administration of an anæsthetic in every case where the pain is severe. Authors generally say that occasionally an anæsthetic may be given. I would be rather inclined to say that one always must be given. Of course in addition, the treatment already mentioned may be employed with the exception of the blood letting which, to say the least, is entirely unnecessary.

As regards treatment to prevent the deposit of renal stone, what I have been in the habit of recommending is careful regulation of the diet and relief as far as possible of dyspeptic symptoms, the drinking of considerable quantities of water which

it is well to have as free from lime as possible; frequent warm baths and the wearing of flannel next the skin; plenty of out door exercise and the avoidance of beer and alcoholic liquors generally. As to medicine I have found nothing give so much relief as carbonate of lithia, in fact I have the greatest confidence in its value in cases of primary renal calculi or a tendency thereto.

Correspondence.

COLLEGE OF PHYSICIANS AND SURGEONS vs. QUACKERY.

To the Editor of the CANADA LANCET.

SIR:—Last fall a quack named Jones came to these enlightened regions, where he remained, doing a first class business, leading the people to believe he had the proper authority to practice, until about a month ago when he suddenly decamped, taking with him the daughter of one of our wealthy farmers, who patronised and opened his house to him. This Jones styled himself "..r. Jones in the profession of roots and herbs, of Milltown, Ont." I was perplexed at the credulity of the people who told me of his doings, but not wishing to bring him before a magistrate, I wrote to Dr. Pyne, who promised to send a detective down, but the said official came too late to catch his victim.

Jones had his board and lodging gratis among the people for nearly nine months, and is said to have made nearly $3000. He is about 6 ft. in height, wears a light moustache, and has the features of a hardened and desperate wretch. The detective was much disappointed to learn of his escape, but as there was enough material of the same kind to work up, he had "Dr." Gardiner of Bannockburn arrested, and fined $28. This man has practiced openly for over ten years in this county; has charged four times more for his medicine than any qualified person, and is let go free for $28. During the last ten years the College has exacted $10 from me, to protect me as I understand it, but if I had followed the advice of medical friends, I would not have paid a dollar, for many of them believe the College to be a farce.

The way that quackery is allowed to flourish here, is not at all encouraging to those who are thoroughly qualified, and besides, it is derogatory to the good name of our time-honored profession. The physicians here have quite enough to do to live respectably, and in many instances they have to establish drug stores, for the practice of medicine would not keep them above want. Yet these quacks who infest our neighborhood, charge just what they please, and collect where we fail. Such practices are a direct encouragement to young men contemplating medicine, to take the road as quacks. The fact is, people seem to have more confidance in the quack, than in the possessor of the M.D., M.R.C.S., etc., etc., and the former makes more money, has less care, and is about as respectable in the eyes of nine-tenths of the people of Canada. With a view to protect ourselves and the public, every physician should, whenever a quack is known to be in his midst, notify the representative of the district of the fact, in order that a detective may be put on his track. It should also be the duty and privilege of the registrar, to erase the name of any member who lends his name and influence, to any travelling concern whose tendency is to deceive the public. Whenever the representatives and the College unite, to protect those who have fulfilled every requirement, all grievances will cease and the profession will be re-instated on its proper level.

PRO ARIS ET FOCIS.

M——, July 20, 1885.

Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

June 2nd, 1885.

The Vice-President in the chair.

Dr. McCargow exhibited the lower end of the femur of a man whose thigh had been amputated in the hospital by Dr. White. The patient, aged 36, had been admitted to the hospital with the following history:—At 14 years of age received a slight injury on the inner side of the thigh, while sleigh riding; since then has had pain in the knee with swelling, chiefly during changes in the weather and in cold weather. Although knee has pained since the first with the exception of slight intermissions of a few weeks, he has never been confined to bed, and the only treatment has been in the form of external applications. Four months ago incisions were made and a large quantity of pus removed. When admitted, the lower half of

the right femur was found enlarged and hard. The swelling extended to the lower half of the right knee, and the patella was fixed; two openings had been made one on the outer, the other on the inner side of the thigh; the openings had partially closed, but there remained small sinuses from which pus discharged pretty freely. Patient was able to move about on crutches and was not confined to his bed in the ward. Family and personal history were both good, no record of anything specific A longitudinal section of the bone was shown; there was an abscess cavity in the centre, with thickening and enlargement of the bone. The cavity was six inches long, one half inch wide, but irregular. The cartilage of the knee was intact. The diseased bone was twelve inches long altogether. Dr. Malloch said that when the section of the bone was made there was a piece of necrosed bone in the cavity which would account for the inflammation.

Dr. R. R. Wallace read a paper on "Incisions in Whitlow." Authorities were quoted to show the site of incision preferred. Erichsen recommended an incision on each side of the finger, while Fairlie Clarke advocated incision on one side; others preferred the median palmar; Keetley advised two palmar incisions. The essayist thought that incision in the median line over the ungual phalanx would be likely to divide the digital arteries as they there cross to form an arch, while the great argument in favour of the median incision had always been that it avoided such accident. He believed that in whitlow confined to the ungual phalanx, incision along the side, carried to the bone if necessary, is the best one to practice, for it affords exit to all pus and sloughs, and effectually relieves tension, thus removing the great cause of the agonizing pain, and avoiding at the same time a cicatrix on the most exposed portion of the finger where it impairs more or less the tactile sense. If the incision on one side was not sufficient, the double one should be practiced. When the disease had extended up the finger, and involved the sheath of the tendons, he thought there was no choice but to open the sheath and give exit to the pus, and this he considered was best done in the median line on the palmar aspect. With regard to the question of one long incision or separate ones between the joints, he thought that the arguments in favor of separate ones were very strong, as there is less liability of causing strangulation over the shafts of the phalanges, and the tendons were not so much exposed or injured by the smaller incisions and the liability of sloughing lessened. Dr. Malloch expressed his surprise at the advocacy of the lateral incision. He said that Ashhurst recommended it because it avoided sloughing, but he himself had never seen it result from the median when incision was made early enough; the only difficulty was in keeping the incisions open, it being necessary to use the probe night and morning. The lateral incision, he thought, would go indirectly to the matter; there was no danger in wounding the arteries and nerves as they would heal readily enough. Other members who spoke all favored the median incision and a good free one.

The Vice-President, Dr. Stark, then showed a specimen, the first phalanx of the middle finger of the left hand. The history of the case was a blow followed by a swelling on the side of the finger, but not much pain; it was poulticed, but an incision was not allowed at first, and when opened it had to be done several times, and finally amputated, and was found to be much expanded, necrosis having evidently taken place.

July 7th, 1885.

The President, Dr. White, in the chair.

Specimens were shown by Dr. McCargow of two kidneys containing a number of gummatous growths, the following report being given of the case by Dr. J. Cochrane:—When the patient entered the hospital there was no history of syphilis to be obtained. Soon afterwards two growths like horns appeared on the forehead, evidently of a fibroid nature.—Afterwards chest symptoms appeared, there being effusion, which, after a small amount of fluid was withdrawn by a hypodermic needle, seemed to subside. There was also noticed a gradual hardening of all the glands of the body. Specific treatment was adopted but was of no benefit, the patient dying of exhaustion. Post mortem—there was thickening of the pleura and general adhesions; the cavity contained between eight and twelve ounces of fluid; there was also effusion into the pericardium. The left lung was healthy, but there was great fibroid thickening of the right, there being a fibrous band passing through it from pleura to pleura. Liver and spleen were healthy, but the kidneys were enlarged and congested and contained a num-

ber of large yellow gummata. The peritoneal glands were enlarged, while the glands of the groin were broken down. In reference to this case, Dr. Woolverton, under whose charge the patient had been, stated that at first she had indefinite pains in her legs; the growth on the right frontal region had increased in size up to the time of patient's death. Two months before, she began to have cough and continued elevation of temperature, the dulness extended rapidly and the chest was seen to be enlarged; after the exploratory aspiration the effusion seemed to decrease, and friction râles were heard, so further operation was postponed; the symptoms improved for a while, but afterwards enlargement again took place, and death at the last was rather quicker than expected. The disease of the lungs he considered to be syphilitic.

Dr. Malloch thought that it was a case of tertiary syphilis, and that the swellings on the scalp were not properly interpreted, for if their softness had been considered, they would not have been thought secondary, as they had been suspected to be.

The other specimens shown were a uterus with a growth attached to the fundus of the size of a strawberry, and two intermuscular growths, and a portion of cancerous liver. The history given by Dr. Cochrane was as follows: There were no definite symptoms at first except an inability to retain anything on the stomach, which was thought due to alcoholism; afterwards the condition of the liver was diagnosed. The patient's illness was not of long duration. Post mortem—the liver was found to weigh over five pounds and was studded with cancerous masses, some of them as large as half an orange. In regard to this case, Dr. Mullin inquired if there was any primary seat of the cancer, and was inclined to think it might be in the uterine growths. Dr. McCargow thought it was in the liver itself, and that all the symptoms pointed to malignancy. Dr. Mackelcan inquired if there was any ascites, as in his experience it was generally present in cancer of the liver. Dr. Griffin asked if there was any disease of the pancreas, but none had been observed.

Dr. Hillyer then read a paper on "Typhoid Fever," giving an account of an outbreak of an epidemic character which occurred in the county of Norfolk, in April, 1860. At the time there was a good deal of discussion as to the nature of the outbreak, some of the local physicians calling it typhus, some pernicious, some typho-malarial, and others typhoid, there being such a variety of symptoms as to warrant the differences of opinion. The epidemic extended over an area of from 10 to 12 square miles, amongst a poverty-stricken and hardworking backwoods population. The disease was first noticed amongst lumbermen who had come from Illinois, where a similar epidemic had been raging. Out of five members in the first family attacked, the mother and three children died. The second family attacked were relations, and had visited the infected dwelling while they themselves lived in a one-roomed badly ventilated house. The symptoms presented by those attacked first were typical of the epidemic, and were as follows: epistaxis occurring early with decided chills, followed by fever, flushed and dusky complexion, accelerated pulse, furred tongue, and general feeling of langour and debility. After the first few days when there was an intermission, the fever gradually became continuous. Nervous symptoms also were present, viz: restlessness, aching of the back and limbs, headache and insomnia. The bowels were loose with the characteristic discharge. As the disease advanced, the pain increased in the right iliac region, abdomen became tympanitic, tongue dry, swollen and of a brownish color, which gradually increased to black. A petechial eruption appeared over the body, with sudamina on the neck and portions of the chest; black sordes appeared on the teeth and gums, and delirium with a general typhus condition supervened, while there was a pungent and penetrating odor from the body. The patients evinced great feebleness, while the skin showed great lack of vitality, sloughing taking place on blistered surfaces. Finally the pulse gave way and became excessively frequent and fluttering, the extremities cold and clammy, and the abdomen enormously distended. After referring to some cases which presented different symptoms, and more of a typhus character, there being no enteric symptoms, costiveness being present from the outset, while in others gastric symptoms were most prominent, he proceeded to speak of the contagiousness of the epidemic, instances being noted where those who had gone away to escape the disease had been stricken down with it, while on the other hand, those who had been constant in their attendance had in some cases escaped. Another feature of the epidemic spoken of, was, that for months, wherever its taint

extended, all forms of inflammatory action assumed an asthenic type, and typhoid symptoms were sure to develop. The writer then took up the nature of the epidemic, after which he gave an account of the treatment adopted. This was chiefly of an expectant nature with special treatment of an ordinary kind for the ordinary symptoms. A discussion followed, the general idea being that the epidemic was one of typhoid. Some conversation also took place on the question of what constituted typhoid fever, and whether it could exist without the special enteric symptoms.

NOVA SCOTIA MEDICAL SOCIETY.

This Society met at Halifax on Wednesday, June 17th, the President, Dr. Macpherson, of North Sydney, C.B., in the chair. Dr. Sinclair read an interesting paper on "New Remedies in Insanity and other Diseases of the Nervous System," and reviewed the evidence in favour of the four following remedies: 1. Paraldehyde. This drug was first introduced by Cernello, of Palermo, in 1882. It is formed from an aldehyde or dehydrogenated alcohol by the action of an acid, and has the formula $C_6H_{12}O_2$. When acted upon by chlorine it is said to be converted into chloral. It is a sedative and hypnotic, and its advocates claim that it has all the good qualities of chloral without its dangers. No nausea, depression or headache have been known to follow its free administration. The taste is disagreeable and difficult to disguise; the best vehicle is ice water in large quantity. The dose of paraldehyde is ʒss. to ʒi. Dr. Andrews, who had experimented largely with the drug, thought it supplied no demand not already met by other agents, which had their own advantages. 2. Nitro-Glycerine, or Glonoine. The theory of its action is, that it reduces arterial tension by paralyzing the vaso-motor nerves, thereby dilating the blood vessels. It has been recommended in angina pectoris, valvular disease, weak dilated heart, albuminuria, chronic Bright's disease, asthma, epilepsy, migraine, and some forms of insanity. Dr. Sinclair's experience both with this drug and with nitrite of amyl, was that in epilepsy the number of fits were increased. 3. Jamaica dogwood (Piscidia Erythrina). He used it in doses of fifteen minims to ʒij. of the fluid extract. As an hypnotic it failed but proved satisfactory as an anodyne. In the severe frontal headache of epileptics, one drachm doses either alone or in combination with bromide of potassium or chloral produced unquestionable benefit. In two cases of dysmenorrhœa, relief of most agonizing pain was speedily obtained. 4. Hyoscyamine and hyoscine. The writer began his experiments with the crystals, using a solution in glycerine and alcohol, and giving it in doses of 1/6 to 1/4 of a grain. In acute mania he produced the full physiological effects, and even when its toxic effects were present only temporary quiet was produced. Pushed to this extent grave symptoms were produced, such as irregular pulse and respiration, congestion of the head and face, cyanosis and dryness of the mouth and fauces. The freshly made fluid extract of hyoscyamus in doses of ʒss. to ʒiss. gave much better results. He has practically discarded the crystals. The amorphous hyoscyamine is essentially distinct from the crystals and consists of at least two crystallizable salts, and to this compound it is proposed to apply the name hyoscine. It is a feeble sedative to the spinal and respiratory nerve centres and a dominant hypnotic upon the brain. In doses of $\frac{1}{160}$ gr. hypodermically it produces calm and sometimes sleep. Dr. Wood used it in nine cases of insanity with great violence and sleeplessness. In all cases quiet resulted and in some sleep, varying from 4 to 6 hours. He recommends it in asthma, whooping cough, and delirium tremens.

A discussion followed in which Drs. Parker, J. F. Black, Smith and Lindsay took part.

Dr. Farrell read a paper on "Excision of Joints," and gave the results of cases treated by him in the Halifax Hospital. Two patients were exhibited in whom the elbow had been excised with excellent results. The other cases referred to were, two of the knee and three of the hip. He laid great stress upon operating before suppuration began to discharge externally. For scrofulous arthritis, excision in almost all cases, is advisable. Under six and after forty the mortality is much greater than at intervening ages. Resection of the hip will be more frequently performed, the mortality being 25 per cent., when left alone 50 per cent.

An interesting discussion followed in which Drs. Muir, Macdonald, Stewart and Somers took part.

Dr. J. F. Black read a very interesting and lengthy paper on "American Medical Institutions," being notes taken in his recent visit to the hospitals of Montreal, New York and Philadelphia.

Dr. J. W. Macdonald read a paper on "Dynamite Accidents," with cases occurring in his practice as Medical Officer of the Steel Company of Canada. During the last five years he had found that an accident had occurred for every seven tons of the explosive used.

Dr. Dodge read an interesting paper on "Injuries of the Eye," with cases from his own practice. These cases were intended to illustrate various forms of injury to the cornea, iris and lens. Wounds of the cornea when made with a sharp cutting instrument were not necessarily serious, unless from their extent. When made with a rough irregular edge they were often very difficult cases to deal with. If the iris were wounded at the same time the injury was more formidable; and very soon severe inflammation led to more or less loss of sight, and if treatment were delayed for a few days total loss of vision frequently ensued. Wounds of the lens also often proved serious. Two very interesting cases were related in which a piece of metal was lodged in the iris; another a case of injury from gunpowder destroying the transparency of the greater part of the cornea, except the upper border, which was partly concealed by the lid. Iridectomy was afterwards performed and section of the superior rectus was subsequently made to uncover the clear portion of the cornea, allowing the ball to roll downwards and thus assist the sight. A case of wound of the cornea extending into the sclerotic was next given. A stitch was placed in the sclerotic and a good result followed.

Dr. Andrews read notes of a case of "Rupture of the Kidney," and Dr. DeWitt reported two cases of empyema successfully treated. Want of space prevents extended reference to these valuable papers.

Dr. A. P. Reed read a paper on "The progress of Medicine." Dr. Campbell on "Heredity as a Causative Influence in Progressive Muscular Atrophy." Dr. Moore on a peculiar case of "Mental Derangement due to Excessive Use of Alcohol." Dr. Stewart on "Physical Education," and Dr. Mackay (Reserve Mine), on "Cases of Obstetric Interest."

By a resolution of the Society Drs. Macdonald, Stewart and Mackay were requested to have their papers published.

The following officers were elected for the ensuing year: Dr. Stewart (Pictou), President; Drs. Sinclair and Mackay, Vice-Pres.; Dr. J. W. Macdonald, Secretary and Treasurer.

Selected Articles.

STRICTURE OF THE URETHRA.

The following cases of stricture of the urethra, under the care of Mr. Paul, Royal Southern Hospital, Liverpool, which we publish, are of interest, each of them being complicated and requiring special treatment. Wheelhouse's operation, which was performed in one case, was described by him in 1876; but, as Mr. Paul observes, it is not necessary to use the special instruments then brought forward, success being equally obtained with instruments which are in almost daily use.

CASE 1.—Josiah C——, aged fifty-four, a seaman, had suffered many years from stricture (he says thirty), but had never been treated for it. He sought admission on account of a perineal abscess. Under ether the abscess was opened, the stricture divided, and a full-sized gum-elastic catheter passed and tied in. On the third day the catheter came out and was not reintroduced, a Lister's bougie being passed daily instead. At the end of two months he was discharged almost well, but warned to attend as an out-patient for some time to get the bougie passed, as the stricture showed a strong tendency to contract again. He was an extremely nervous man, and once out of the hospital had not the pluck to continue treatment, the result being that in the course of a few months he had another urinary abscess worse than the first. He kept away from the hospital until he found that he was getting in a very bad way, when he returned in the following condition: the scrotum and the whole of the perineum and neighboring parts were brawney and tender. Just behind the former was a ragged, foul-smelling sore, eating deeply into the perineum along the tract of the original fistula. Its edges were hard and epitheliomatous in appearance, and upon scraping the surface of the sore the characteristic "nest cells" were found in abundance. The disease was too far advanced to permit of any attempt at removal, and came to a fatal end in about three months, the actual cause of death being cellulitis. At the post-mortem the growth was found to be limited to the perineum and neighboring glands, involving all the parts down to the arch of the pubis and spreading freely into the scrotum. The prostate and bladder were quite free.

Remarks.—I believe that this is a very rare sequence to a urinary fistula, and it is very unfortunate that there were no means by which the exact origin of the epithelioma could be determined. It is difficult to distinguish microscopically epithelioma of the bladder from epithelioma of the skin, and the same holds good with the urethra. The whole case lasted only ten months. When first seen, the skin of the perineum was unbroken, it was quite free from growth two months later,

and then, at the end of another five months, was the site of a large and very deep epithelioma. Under these circumstances, I inclined to the opinion that the growth commenced in the urethra, and was excited by the prolonged stricture; just as simple syphilitic stricture of the œsophagus sometimes ends in epithelioma of that structure.

CASE 2—James P——, aged thirty-four, had gonorrhœa when a lad and had suffered from stricture for the last sixteen years. He had often been under treatment at the various hospitals in the town, but had never had anything larger than a No. 6 or 7 passed, except on one occasion when Mr. Harrison ruptured the stricture with Holt's dilator. After this he learnt to pass a catheter for himself, but had only used the smaller sizes, and came to the hospital, as he could get nothing more in and was scarcely able to pass his urine. On admission, he was in good general health. There was a cartilaginous stricture in the perineum which would just admit the smallest soft bougie. The urine was foul and contained a quantity of mucus. At the end of three days no dilatation had been effected with catheterism, and the bladder symptoms were becoming more urgent; Wheelhouse's operation was therefore performed at once. The patient was placed in the lithotomy position, and a long silver probe passed down to the stricture. An incision was then made on to the end of the probe, which was pushed out of the wound and bent into a hook. The sides of the urethra were held open with artery forceps, a grooved probe insinuated through the stricture, which was divided, and the probe passed on into the bladder. It was now quite easy to pass a full-sized Lister's bougie from the penis to the bladder; so the patient was sent back to bed without having a catheter tied in. At the end of a week the urine was quite clear and all irritation of the bladder had ceased; so, instead of the daily passage of a bougie, a large gum-elastic catheter was tied in. While the catheter was kept in all the urine came by it, and the wound healed rapidly. It was removed in ten days, and the patient taught to pass a No. 12 Lister's bougie, and discharged a few days later. Altogether he was in the hospital only from Jan. 12th to Feb. 7th.

Remarks.—I send this straightforward case for publication because I have so often felt the advantage of an early operation of this nature in stricture cases, and because I often notice that my surgical friends, while they laud the method advocated by Mr. Wheelhouse very rarely seem to adopt it. In the hands of specialists internal operations upon the urethra are much in vogue; at present I have never either split or divided internally a stricture, except in the penis, preferring in all cases where an operation is necessary to do perineal section. I think it is a pity that Mr. Wheelhouse recommends special instruments for his operation, as it is quite as easy to do it with those always at hand; and, with all due deference to his opinion, I do not find his sound and gorget of any material assistance, while their absence might influence some to attempt a different method of giving the necessary relief to the patient. In this case a catheter was not tied in at once on account of the cystitis; and at the conclusion of the treatment I adopted my usual practice of teaching the patient to pass a large metal sound for himself. It is the only permanent cure for most strictures, though but few, of the hospital class at any rate, are wise enough to adopt it.

CASE 3.—James F——, aged twenty-seven, had gonorrhœa some years ago, but passed urine in a full stream until about twelve months back, when he had his first attack of retention of urine after a drinking bout. Since then, under similar circumstances, he has had three or four more attacks of retention, and at the same time the stream of urine has been steadily diminishing in volume during the intervals. On Feb. 2nd he was drinking, and on the morning of the 3rd was again attacked with sudden and complete retention. Relief had been attempted by catheter, and he bled profusely, but no urine was drawn off. He was admitted with the bladder moderately distended in the afternoon, and was in great pain. A metal catheter was passed into the urethra, but opposite the bulb left it for a false passage, and on withdrawing the instrument he at once strained away about an ounce of blood. Under these circumstances a morphia injection was given, and he was ordered to have a hot bath shortly, to be followed by hot fomentations to the abdomen, and further morphia if necessary. In the evening, though the treatment had given some relief, not a drop of urine had been passed, and it was therefore deemed advisable to puncture per rectum. The next day he was perfectly comfortable, and the urine was draining freely through the canula. On the 5th, after plugging the tube, he was able to pass urine by the penis, and it was consequently withdrawn. 6th.—Had a rigor, with nausea, headache, and diarrhœa. Temperature 104°. Ordered five grains of quinine every four hours. 7th.—Temperature fell below 100°, and became normal in a few days. The quinine was stopped on the 9th. 12th.—Soft bougies passed. No. 3 was the first to be gripped by the stricture, which was dilated to No. 6. 24th.—The patient was discharged with the stricture fully dilated.

Remarks.—In a case of this kind, I think the choice lay simply between aspiration of the bladder and puncture per rectum. I chose the latter entirely on account of the false passage. In acute retention, when, though the urethra is uninjured, no instrument can be passed, aspiration is called for, and will almost invariably not have to be repeated, since the relief afforded by it, together

with other suitable treatment, will permit the swelling and spasm of the urethra to subside, and in the course of twelve hours either the patient will have passed urine naturally, or it will be possible to introduce a catheter. But when a false passage is present, and it is extremely unadvisable to interfere with the urethra for a least a week or ten days, the better plan is certainly to adopt puncture per rectum, and retain the canula *in situ* until the power to micturate has returned. The pyrexial attack on the 6th I believe to have been due to some urine filtering into the false passage and permitting septic absorption, as no instrument was passed until the 12th, and no trouble of any kind appeared in connection with the rectal puncture. I am a strong advocate for early operation in all cases of obstruction to the outflow of urine, when that obstruction cannot be easily overcome by catheterism. We ought to remember that the kidneys are the only part of the urinary tract of vital importance, and, sooner than permit their structure to be damaged, a clean incision should always be made into the urethra or bladder, as the case may require. Sadly too often, while we are wasting time over a cartilaginous stricture with small bougies, pyelitis is grafted on to cystitis, and suppurative nephritis may develop at any moment, and show too late the danger of delay.—*Lancet.*

A CASE OF TRAUMATIC ANEURISM.—In the *New York Medical Journal* for May 23rd Dr. Theodore McGraw of Detroit relates an interesting case of traumatic aneurism of the subscapular artery. The patient was a Pole twenty-seven years of age, who received three stabs about the shoulder in December, 1881, one of which was followed by an enormous extravasation of blood that was in due course absorbed. Three years later he came under Dr. McGraw's care with a rapidly growing pulsating swelling in the axilla, which had all the usual characters of an aneurism. There was no alteration of the radial pulse. Its increase in size was so rapid that treatment had to be resorted to at once. The first step of the operation was to make an incision above the clavicle, through which the subclavian artery could be compressed. A free incision was then made over the tumour, and carried through the pectoralis major muscle, and attempts were made to detach the thick sac of the aneurism from the surrounding structures. When this step of the operation was about half completed, the sac ruptured, and thinking that the attempt to isolate it must be abandoned, the sac was freely laid open, and the mouth of the artery controlled by the finger; but after many efforts it was found quite impracticable to free the mouth of the artery and to throw a ligature around it, for the sac was formed of very dense tissue, and was firmly adherent around the wounded artery. Dr. McGraw thereupon returned to his original plan, and with ease separated the fundus of the sac from the ribs and the anterior and posterior walls of the axilla, and then ligatured its neck. After this the axillary artery was with comparative ease freed and tied above and below the origin of the subscapular branch, which was found to open into the aneurism within half an inch from the parent trunk. Arguing from this case, Dr. McGraw advises that while Syme's operation is suitable for cases of ruptured artery, it should not be adopted for traumatic aneurism where there is a well-formed sac. It is pointed out that it may be impossible from the interior of an aneurism to free the artery sufficiently to ligature it without imperilling contiguous arteries, veins, or nerves, while the detachment of the sac may be a comparatively easy and rapid procedure if done systematically. A ligature can then be tied around the neck of the tumour, and all danger of hemorrhage avoided, and if the fundus of the sac be cut away the field is comparatively clear for the final steps of the operation. It is undoubtedly a dangerous and difficult matter to clear an artery from the inside of the sac of an aneurism, and where the sac is sufficiently dense to permit of it, the plan of operating proposed by Dr. McGraw offers decided advantages.—*Lancet.*

THE USE AND ABUSE OF THE TAMPON IN ABORTION.—The tampon as a means of arresting hæmmorrhage from the cavities of the body or from wounds has been known to the profession for many years. It seems a very natural thing, when blood is escaping with dangerous rapidity, to apply a plug of some sort to stop the leak. There are some things to be guarded against, however. That the bleeding is actually arrested, and not merely diverted into another channel, is of primary importance. Again, there are conditions in which the plug may do mischief. As applied to uterine hæmorrhages, these two elementary principles are so well known that no one will question the correctness of either. A woman with the vagina firmly plugged may bleed to death into the cavity of the uterus. A tampon allowed to remain too long may do harm in various ways. A tampon injudiciously applied may precipitate the catastrophe it was intended to avert. Of this injudicious application of the tampon in cases of threatened abortion it is the purpose of this paper to treat.

Dr. Keene then quotes the views of Leishman, Playfair, Tyler Smith, Cazeaux, Shroeder, Lusk and others and says: Now, out of this mass of authority, sometimes conflicting, but generally unanimous, what deductions are to be drawn? That the tampon is to be used as a last resort, and only where the hæmorrhage is dangerous or the abortion clearly inevitable. We have, moreover, the observation of so experienced an obstetrician as Shroeder, that the hæmorrhage of abortion is seldom dangerous and scarcely ever fatal—a view which

Lusk seems to share. Of course, in their hospital experience, a physician is always at hand to meet any emergency, while in private practice, and especially in the country, another condition of things prevails. Yet it seems that enough has been said to indicate plainly that the routine practice of plugging, in threatened abortion with but slight hæmorrhage, merely as a precautionary proceeding, has no countenance from the authorities.

Besides the natural bias of the physician's mental makeup—his individual personal equation—his views will vary as his experience has been large or small. To a beginner, the loss of a slight amount of blood from the uterus of a pregnant woman is fraught with direful forebodings. As his experience widens, hæmorrhage will become dangerous less frequently, abortion will take its place under the inevitable class with much less facility, and the tampon will be employed only to fulfil its two legitimate indications.

The young practitioner is not the only offender in the over-free use of the tampon. His older brother may well look to the well-worn grooves in which his practice moves more or less smoothly to discover whether he, too is not a devotee of the tenet that the fœtus has no rights which the physician is bound to respect. The tampon is legitimately employed only when for good and sufficient reasons it is necessay to terminate gestation.—*Dr. J. W. Keene, New York Med. Journal.*

Confession No Proof of Guilt.—The *Lyon Medical*, of April 28th, 1882, refers to the case of a girl, aged twenty, supposed to be seven months pregnant. After an attack of hemorrhage, her size seemed to have considerably diminished; and the girl being closely questioned on the subject, said that, becoming aware of the discharge, she repaired to the closet, where she stayed ten minutes. She added that all had escaped, but that she had not time to look, as she was being called by her mistress. A midwife and the parish surgeon both declared that the girl had been recently confined. She was now again assailed with questions, and told that, for her own sake, she had better make a clean breast of it, as no fœtus had been found in the closet. Perhaps, it was suggested, she had thrown it into the pigsty. The poor creature at first denied such a thing, but at last confessed that it was so. A search was made but no child was discovered. She was tried for concealment of birth, on her own confession, and sentenced to six months imprisonment. The girl had not been taken into custody in consideration of her free confession, and she quietly proceeded to the goal. When admitted, it was found that she was far advanced in pregnancy, and soon gave birth to a healthy girl. By the French law she could no longer appeal, as more than ten days had elapsed since the verdict; but the judge, having the power of appealing within two months, did so, and the girl was acquitted.

This case shows that confession, which is looked upon as the clearest proof of guilt, can not always be relied upon. And what shall we say of the surgeon and midwife? The examination was probably hurried and incomplete, and the conclusion arrived at on seeing the signs of recent abundant hemorrhage. This case, even in a simple obstetrical point of view, is full of valuable hints.

Treatment of Hemorrhage after Operations on the Rectum.—Mr. Samuel Benton (*British Medical Journal*) brings to the notice of the profession a useful instrument for checking hemorrhage after rectal operations. It consists essentially of a piece of catheter tubing surrounded by a bag of thin rubber. When introduced into the rectum, the rubber bag is inflated to any extent required, and so a considerable amount of pressure may be brought to bear on the bleeding surface, in the same way that a similar apparatus is used for the relief of epistaxis. Mr. Benton's bag is constricted in the middle (like a Barnes' bag), so the amount of pressure on the sphincter will not be too severe. The catheter tube, by allowing the escape of flatus, contributes much to the comfort of the patient. The inventor considers that, in addition to its use as a hæmostatic, it will prove serviceable in the treatment of some rectal diseases where even pressure is indicated, as in non-malignant tumors of the rectum.—*Annals of Surgery.*

Endocarditis.—When endocarditis is found to be present, Dr. C. Paul, *L'Union Méd.*, applies a large blister over the region of the heart, orders rest, and prescribes some cool acidualted drink. If the disease occurs with articular rheumatism and sali-cylate of soda or sulphate of quinine is found efficacious, its use is continued as long as the pulse is not too rapid and irregular. If, however, the heart's action is disturbed, tincture of digitalis is to be given in doses of twenty drops twice a day, and gradually increased to sixty or eighty drops. The dose should not be increased until two days have elapsed, and as soon as the heart's action becomes regular the remedy may be diminished in quantity or suspended. The tincture of convallaria maialis, in doses of seventy-five minims per diem, may be given in place of the digitalis. As soon as the pulse becomes regular, recourse must be had to tonics, and especially the soluble ferruginous preparations.—*N. Y. Med. Record*, May 23d.

Bronchitis with Valvular Heart Disease.—Prof. Bruen, Phila., at his clinic, speaking of such a case, said:

My own experience in the treatment of simple bronchitis has been that the expectorants designed to increase secretion of the bronchial mucous membrane may be at first freely given; but their

use should not be prolonged, but should soon be substituted by the stimulative expectorants. I have found that if the bronchitis is not rapidly cured by these, but passes into a subacute condition, more can be accomplished by building up the general strength than by acting on the bronchial mucous membrane directly. In cases of cardiac bronchitis a great deal can be accomplished by building, not only by acting on the heart directly, but also by the use of such drugs as strychnia, arsenic, and iron.

We shall prescribe for this man the following pill:

℞ Strychniæ sulphatis,
Acid. arseniosi aa gr. ss.
Pil. ferri carb. grs. xxiv.
Oleo-resinæ capsici gtt. vj.
Extracti gentian grs. xij.
M. et. ft. pil. No. 24.
Sig.—One, three times a day.

An especial reason for using strychnia is that it increases the depth of the respirations, and thereby facilitates oxygenation of the blood, which is interfered with by the weak heart.—*Med. & Surg. Rep.*, May 23rd.

Hay Fever and its Treatment.—In this connection we may call attention to the new work of Dr. Sajous on "Hay Fever and its Successful Treatment." According to his views, hay fever would exemplify that form of asthma which Curschmann has never met,—the form in which the cause resides in the brain and nervous paths which lead from the brain to the respiratory apparatus. For, according to Dr. Sajous, persons subject to hay æthma possess, as the result of heredity, diseases implicating markedly the nervous system, nerve centres which have become abnormally sensitive and are therefore inordinately influenced by the external irritants to which they respond. But this is not the whole of the pathology of hay asthma, according to Dr. Sajous. Not only must there be a hyper-excitability of the nerve centres, but the nasal mucous membrane must be hyperæsthetic, and capable of transmitting to the abnormally sensitive nerve centres the impression made upon them by external irritants, which are supposed to be the pollen of flowers and certain other unknown elements which prevail only from June to September. Given the absence of any one of these conditions and the patient is spared the attack. The absence of the physical element, whatever it may be, which causes the irritation may be secured by removal to certain localities where it does not prevail.

Dr. Sajous secures the removal of the irritable mucous membrane by eliminating, first, the abnormal conditions of the mucous membrane, that is the swellings, hyperostoses, etc., by suitable treatment; and second, by cauterizing the hyperæsthetic nasal mucous membrane, and thus rendering it insusceptible to the irritating agencies. This is the new and successful treatment of hay asthma, in the early use of which Drs. W. H. Daly, of Pittsburg, J. A. Roe, of Rochester, and Prof. Harrison Allen, of Philadelphia, have, also, been conspicuous. We sincerely hope that further experience may confirm these preliminary statements, and that "hay" or "rose" asthma may no longer be the opprobrium it has always been to the science of medicine—*Med. News.*

Cocaine in Burns.—Dr. Weiss writes:—On December 25th, I was called to Professor L——. An atomiser he was using had exploded, and the hot steam badly scalded the Professor's lips, nose, cheeks, and forehead. Pain was so intense that I apprehended general convulsions. I sent for sundry topical remedies, amongst them a two per cent solution of hydrochlorate of cocaine. In the meanwhile I covered the injured parts with pieces of cloth dipped in olive oil; on the top of these I applied ice water compresses, renewing them every minute, without affording the slightest relief. When the medicaments arrived, I touched the injured parts with a hair-pencil dipped in the cocaine solution. I had scarcely finished when all pain had entirely vanished, without any return. At my visit in the evening I found the patient quite easy and in good spirits.—*Wiener med. Woch.* Jan. 8, 1885.

[It is also useful in the treatment of sore nipples.]

An Ingenious Expedient.—Recently I was called to examine a woman who has had vesico-vaginal fistula for years. The sufferer has kept herself cleanly and comfortable by using in the vagina a globular pessary made of compact sponge. The fistulous opening is near the urethral outlet; and the pessary holds the false orifice so high that the urine can be retained for hours. The patient never urinates, but evacuates the bladder every three or four hours through the agency of a catheter—an instrument she has become expert in using. The expedient might possibly be adopted in some cases where an operation for closure of the rent is not practicable. I commend the ingenuity of the woman who, unaided by even a professional suggestion, has kept herself from being offensive to herself and others.—*Eclectic Medical Journal.*

Enteritis Caused by Corrosive Sublimate.—Dr. J. L. Peabody read a paper recently before the Practitioner's Society of New York, on toxic enteritis caused by corrosive sublimate as a surgical dressing. Attention was first directed to this by reports of cases found in German medical journals. In the records of the New York Hospital eleven cases were recorded in which an obstinate diarrhœa followed the use of sublimate as a surgical dressing. Seven of these proved fatal. Autopsies in three of them showed extensive diphtheritic inflammation of the large intestine.

THE CANADA LANCET.

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☞ *Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

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INTERNATIONAL MEDICAL CONGRESS.

Our readers are already aware that it is intended to hold the International Medical Congress in Washington in 1877. A committee of arrangements consisting of seven members, with power to add to its numbers, was appointed at the meeting of the American Medical Association in 1884, to extend an invitation to the Congress to meet at Washington, and in case of an acceptance, to make all necessary arrangements for the meeting and to solicit funds for that purpose. This committee was composed of Drs. Austin Flint, Sr., and L. A. Sayre, New York; I. Minis Hays, Philadelphia; C. Johnson, Baltimore; H. F. Campbell, Georgia, and J. S. Billings and J. M. Browne, of the U. S. army and navy respectively. The invitation was accepted, and to this committee about twenty additional members were added, among others, some "new code" men of note, and a meeting was held in Washington and a plan of organization adopted. The list of officers, and numbers of sections (nineteen in all) were published in the medical journals of the United States and foreign countries, and met with general approval. Everything went smoothly as a marriage bell until the meeting of the American Medical Association in New Orleans in May last, when a few turbulent spirits of the "rule or ruin" type, to be found in all assemblies, took exception to the action of the committee on the ground, first, that it had recognized "new code" men; and, secondly, that the south and west were not fairly represented in the Congress, the majority of the officers having been chosen from among the eminent names in the East—New York, Boston and Philadelphia. "New code" prejudices and local jealousies were too much for the serenity of the Association, and the upshot was the appointment of a mammoth committee of 38 members, representing every State and Territory in the Union, Army, Navy, etc., to be added to the original committee, with power to alter or amend the action of the former committee, as it might deem best. This committee met in Chicago on the 24th of June, and, as might have been expected, there was a lively time. Only two members of the original committee put in an appearance, viz., Drs. J. S. Billings and I. Minis Hays, while twenty-four of the new members were present. Dr. Cole, of California, was appointed chairman, and Dr. Shoemaker (one of the leaders in the crusade against the original committee) was appointed secretary. The committee then proceeded to the work of revision. They first deposed Dr. Bowditch, of Boston, from the vice-presidency of the Congress, because of alleged "new code" sympathies. The following chairmen of sections ("new coders") were also deposed, viz., Dr. Noyes, on Ophthalmology, Dr. Lefferts, on Laryngology, and Dr. Jacobi, on Diseases of Children. The nineteen sections were reduced to sixteen, and the membership of the Congress was confined to delegates from the American Medical Association and societies in affiliation with it, thus excluding all from the Congress who are not in full sympathy with the American Association, and carrying the "code" quarrel into the Congress. When the result of the committee's deliberations became known, meetings of those interested were held in Boston, New York, Philadelphia, Baltimore and Washington, and resolutions were passed expressive of disapproval of the action of the committee, and refusing to have anything to do with the Congress under the present regime.

This action on the part of the leading members of the profession seems a most serious step, but it arises from the fact that there is a growing want of confidence in the ability of the American Medical Association, as an organization, to carry out such an undertaking satisfactorily, and also in the pro-

bable success of any Congress from which the best known scientific men of the country are excluded. The action of the committee in regard to the "new code" men would indeed be ludicrous were it not so serious, and will have the effect of creating sympathy, where before there was only cold and formal respect. The insult offered to such veterans as Bowditch, Fordyce Barker, Draper, Weir, Mundé, Roosa, Knapp, Noyes, Agnew, Jacobi, and others, merely because of a difference of opinion on the code question, will not be tolerated by the good sense of the American medical profession.

We presume matters will probably remain in *statu quo* until the next meeting of the Association in St. Louis, when the whole question will be gone over again. We have faith in the good judgment of the medical profession, and believe that a way will be found out of the confusion and complication into which this matter has drifted.

SUICIDE AND THE MEDICAL PROFESSION IN ILLINOIS.

The oft-repeated remark, that doctors carry on their shoulders more than a full share of the troubles of this life, finds a curious confirmation in the last necrological report of the Illinois State Board of Health. In this report are to be found a few unpretending figures, which, upon a more careful examination than that bestowed by the compiler, are found to be full of meaning and melancholy interest. It is to be hoped that in its next report the Illinois State Board of Health will supplement its figures by as full information as possible regarding some important points touching that part of their report to which we call attention. In this report it is stated that 202 physicians died during the previous year in Illinois. Of this number, six are reported as having died from suicide, five from "overdose of morphia," and two from "overdose of chloral." The reported suicides form about three per cent. of the deaths, a percentage in itself out of all proportion to what obtains amongst other classes of the population. But in addition, seven deaths are reported as having occurred from overdose of morphia and chloral—or over three per cent. of the total deaths. We all know that suicides take place which are never reported. Relatives and friends have numerous motives for suppressing the facts. This is comparatively easy in the case of invalids or chronic drinkers, especially when sedatives are the weapons of self-destruction resorted to. If this be true as regards the general public, it is much more so as regards medical men, who have every facility for quietly ending their own lives in this way. In the report before us it is not stated that a single physician died from the careless or accidental use of any other poisonous agent. This looks suspicious. Of course medical men, like other mortals, have aches and pains to soothe, and suffer from insomnia, but that is no reason why they should kill themselves in greater numbers than they do their patients. The unvarnished truth is, that the "overdose," as regards the seven cases above mentioned, was simply the invention of friends interested in suppressing the real facts. If we allow two deaths by overdose, which is quite enough, that will make eleven deaths by suicide, instead of six as reported. We cannot be far astray in our estimate of the "overdose" cases in this instance, but when we come to estimate the number of unreported suicides we have entered the field of conjecture, and each one will have his own opinion. No one will deny but such occurred, while many will be apt to conclude that the number is relatively considerable. In the instance before us we shall suppose that three such cases occurred. That will give us fourteen suicides out of 202 deaths, or about seven per cent. Where so many suicides take place there must be a great many in the profession living in a state of utter misery and despair.

In this country we feel thankful to be able to say that no approach to such a condition exists. It is rarely, indeed, that a medical man in Canada dies by the act of his own hand. It would be interesting to know something of the professional standing and habits of these Illinois suicides, for that would afford some clue as to the cause or causes of a condition of things which we hope is exceptional, even as regards the other States of the Union. In this country insanity and drink are regarded as almost the sole causes of suicide in the case of medical men, especially the latter cause. But the native American is temperate, and we are assured that the great majority of American doctors are total abstainers. Drunkenness, therefore, cannot be said to be the most important factor. The most fruitful cause, most probably, is the over-

crowding consequent upon a low standard of general and professional education, or the absence of any standard worthy of the name. In the United States there is one doctor (so called) to every 600 of the population, and Illinois has its full quota, although it has rid itself, through the aid of recent legislation, of a large number of its quacks. The better element, under the new law, is forcing quackery into the background, and as a consequence we may safely assume, the most incompetent find themselves in desperate straits as the people become informed, and as medical men in increasing numbers become better educated, both in a literary and professional sense, so as to take a higher stand —not only professionally, but socially as well— the harder will be the lot of the poorly qualified and the mere charlatan. Perhaps, after all, it is better for society that these should continue the process of self-destruction than go on taking the lives of others.

The profession in Ontario, no less than the people at large, have much to be thankful for. Here no one can publicly practice who has not been found qualified after strict examination. This examination is not made by distinct schools, colleges or authorities, but by appointment of a central and independent authority called the Medical Council. This Council not being the creation, and hence not the creature of any existing authority save the law that constituted it, but a true representation of the profession by fair and open election, and as it is clothed with unlimited power, both as to the preliminary and final fitness of candidates, no one need fear that the standard will ever be too low or that the ranks will ever become much more crowded than they are. When undue overcrowding does take place, the remedy lies in raising the standard, and this power lies in the Council. No country can show brighter, better educated, or more able men in all respects, than the United States of America, yet, owing to imperfect laws, or the absence of all law, no country is so overrun with uneducated and half-educated doctors. Year by year the lot of the mere pretender will become harder and harder. All over the Union restrictive laws are fast replacing "free trade," and everywhere education and professional skill are becoming more and more in demand.

In view of these and other facts which might be mentioned, it is the duty of every one of us to stand firmly by our privileges, to hold them fast, and to support our representatives in the performance of their duties by a cheerful compliance with the reasonable demands made upon us. The medical men of any State in the Union, would only be too glad to tax themselves ten times the amount asked of us for like privileges and immunities.

CANADA MEDICAL ASSOCIATION. — We would specially direct our reader's attention to the notice of meeting of the Canada Medical Association in our advertising pages. It will be seen that on application to the general secretary, Dr. Stewart of Montreal, all regular members of the profession will be furnished with certificates entitling them to purchase tickets at reduced railway rates. We are pleased to learn that the number of papers already promised is a sufficient guarantee that the Chatham meeting will fully equal its predecessors not only in the number, but also in the high value of its communications. The following are the officers of the Association—President, Dr. Osler of Philadelphia; General Secretary, Dr. James Stewart, Montreal; Treasurer, Dr. Charles Sheard, Toronto; Vice-Presidents, Drs. Bray of Chatham, George Ross of Montreal, Allison of St. John, Fraser of Windsor and Whiteford of Winnipeg. Local Secretaries, Drs. Burt of Paris, Bell of Montreal, Walker of St. John, Almon of Halifax, and Mewburn of Winnipeg.

COCAINE IN HAY-FEVER.—Now that the season for hay-fever is upon us it may not be out of place to state that great benefit has been obtained by a number of observers from the use of cocaine. Among others Dr. Watson of the Westminster Hospital, London, Eng., gives an account in the *Lancet* for July 4th, of the benefit obtained by him from the use of tablets of cocaine. The tablet which contains 1/6 of a grain of muriate of cocaine is moistened in the mouth and one introduced into each nostril. They adhere without difficulty and give immediate and complete relief. Menthol in alcohol solution has been used by some as a substitute for cocaine, but is not so lasting in its effect.

CHOLERA INOCULATION.—The French commission has returned home disgusted with Dr. Ferràn's inoculation experiments. He positively refused to allow the commission to carry off a single bit of vaccine matter, or to make known his method of

preparing it. His laboratory is poorly equipped, possessing none of the modern appliances, not even an apparatus for regulating the temperature of the stove in which the cholera virus is cultivated for attenuation. He told the commissioners that he could not surrender his secret without a "guarantee." Dr. Ferràn's whole course of action creates the suspicion that he is either a deluded scientist or a humbug, or both.

PERSONAL.—Dr. W. F. Coleman, formerly of St. John, N. B., has finally settled in Chicago. The following resolution was unanimously adopted by the St. John Medical Society, on his removal from St. John.

Resolved, That this society give expression to their high appreciation of Dr. Coleman's scientific attainments, gentlemanly bearing, and untiring professional zeal. While deeply regretting the loss that the society and the profession will sustain by his removal, we confidently predict for him a very large measure of success in his new sphere, believing, as we do, that he possesses all the elements of a first class practitioner.

JAS. H. GRAY, M.D., *President.*
T. M. MUSGROVE, M.D., *Secretary.*

NEW METHOD OF COMPRESSING THE SUBCLAVIAN ARTERY.—Dr. Joseph Bell exhibited before the Med-chirurg-Society, Edin., (*Lancet*, June 13, '85), a case of amputation of the arm for extensive sarcomatous disease of the scapula. The hemorrhage had been controlled by a method recommended to him by Prof. Chiene, in which a curved steel skewer was passed from above downwards behind the subclavian trunks, and brought out in front through the pectoral muscles. Pressure was exerted on the vessels by an elastic tube applied as a figure-of-8 over the anterior part of the region transfixed, a firm pad intervening between the elastic tubing and the patient's skin. The method is similar to that used by the late Prof. Spence in the case of the femoral artery in amputation at the hip-joint. In this case Dr. Bell found the method perfectly satisfactory, as the limb was removed with the loss of but two ounces of blood.

CARBUNCLE.—Dr. Bulkley read a paper before the American Medical Association on this subject. He is strongly in favor of allowing a carbuncle to break naturally. He contends that when a carbuncle is incised there is more danger of pus being absorbed. He also opposes poultices. He gives sulphite of calcium, in quarter-grain doses, every two hours; sulphate of magnesia, in laxative doses, three times per day, and tonic doses of sulphate of iron. He also makes an application to the carbuncle of solid extract of ergot, two drachms; oxide of zinc, one drachm; and two ounces of rose-water ointment. The preparation is spread upon lint and applied directly. He thinks this reduces pain and cuts short the disease.

DIAGNOSIS OF GONORRHŒA IN THE FEMALE.—The differential diagnosis between gonorrhœa and simple vaginitis, is usually not an easy task. It has recently been asserted, however, by M. Martineau, of Paris, that the pus of gonorrhœa is acid in reaction, while that of simple vaginitis is alkaline. If this be true, a piece of litmus paper will invariably determine the true nature of the case. The test is easily applied, and if reliable its importance is very great.

AMALGAMATION OF MEDICAL COLLEGES.—The Detroit Medical College and Michigan College of Medicine have been recently consolidated, and will begin their first session's work on the 23rd of September next. See announcement in another column.

CORRECTION.—In the article on Intra-Uterine Medication, by Dr. Temple, in our last issue, an error crept in on page 321, eighth line from top, in first column. It should read *one drachm* instead of one ounce.

APPOINTMENTS.—Dr. Wm. McClure has been appointed Medical Superintendent of the Montreal General Hospital.

The *Canadian Practitioner* expresses the hope that the question of "consultations with Homœopaths" will be discussed by the Canada Medical Association at the meeting in Chatham. We can assure our sanguine contemporary that the Association will do nothing of the kind. Moreover, we do not believe that it can be satisfactorily proven that members of the Association are "in the habit of *consulting* with homœopaths and other irregular practitioners."

We regret to announce the sudden and unex-

pected death of the wife of Dr. C. W. Covernton, of this city, in the sixty-sixth year of her age She will be greatly missed by her large family and a numerous circle of friends. The doctor and family have our deepest sympathy in their sad bereavement.

COMPOUND FRACTURES.—Dr. W. P. Verity, of Chicago, read a paper before the American Medical Association on the "Treatment of Compound Fractures by Wiring and Drainage." In all cases of compound comminuted fractures coming under his care, he first cleansed the parts and removed all loose fragments likely to produce irritation. He is, however, opposed to removing any fragments that can be wired, as they are needed for support. All the sharp edges should be removed and the bones firmly wired together, and free drainage provided for by large drainage-tubes. The limb should then be covered with antiseptic dressing and incased in a plaster cast, which should be removed at each dressing. The advantages claimed for his treatment are that there is no shortening, union is more rapid, and no extension is required.

CHRONIC CERVICAL ENDOMETRITIS—Dr. T. Gaillard Thomas speaks highly of the following in this affection :

℞	Magnes sulphatis,	℥ ii ;
	Ferri sulphatis,	gr. xvi ;
	Acid. Sulph. dil.,	℥ i ;
	Aquæ,	O i ;

M.

Sig. Two tablespoonfuls in a tumbler of ice-water daily on risidg.

Dr. RYERSON, of Toronto, acting surgeon of the Royal Grenadiers, who has been away with the North-West expedition, has returned and resumed practice. The Dr. was through the Fish Creek and Batoche engagements, and the subsequent operations of Gen. Middleton's column.

We beg leave to call attention to the elegant inset of Hazen Morse in this and last issue of the LANCET. His preparations have been before the profession for several years, and are constantly growing in professional favor.

Mr. John Eric Erichsen, author of the work on Surgery which bears his name, and Mr. Ernest Hart, editor of the *Brit. Med. Journal*, will be candidates for Parliamentary honors at the next election.

The McIntosh Galvanic and Faradic Co. have been awarded the Gold Medal at the New Orleans Exhibition.

Books and Pamphlets.

CHOLERA : Its origin, history, causation, symptoms, lesions, prevention, and treatment. By Alfred Stillé, M.D., LL.D., etc., etc. Philadelphia : Lea Brothers & Co.

Professor Stillé has contrived to compress into a little octavo of 162 pages all that he has felt called upon to say in relation to the absorbing subject of Asiatic cholera. He is a very decided contagionist. This doctrine seems to be as much favored now, as fifty years ago it was centemned. The logic of stern facts has been too powerful for the fancies of optimistic doctrinaires, and medical men of the present day have awakened to the old fact that two and two make four, and that no quantity of nonsense, added to an unknown quantity of baseless assumption, will be the equivalent of ever so fractional a part of truth. Dr. Stillé may be said to have been on the best terms of authoristic concordance with the writers of the May volume of W. Wood & Co. ; in fact they so reciprocally borrow and lend that they must all be on terms of close amity ; but it is not always easy to say which party is the borrower, and which the lender. We must however be so just as to instance one exception to this mutuality. Dr. Stillé deals rather sternly with Dr. Sternberg's adopted comma bacillus. He says : "It seems no longer possible to accept the bacillar doctrine of the production of cholera." In support of this negation he quotes Koch, on the mortality of the comma bacilli, where he has been so frank as to tell us, that, "even after three hours drying every vestige of life has disappeared." What! so fearfully killing, and yet so easily killed.

A PRACTICAL TREATISE ON URINARY AND RENAL DISEASES, INCLUDING URINARY DEPOSITS. Illustrated by Numerous Cases and Engravings. By William Roberts, M.D., F.R.S., F.R.C.P. (Lond.), Professor of Medicine at the Victoria University, etc., assisted by Robert Maguire, M.D., Lond., F.R.C.P., etc. Fourth Edition. Philadelphia : Lea Bros. & Co. ; Toronto : Vannevar & Co. Price, $3.50.

The work before us is one we can recommend to those in need of a good reliable work on the

above named subject. It is already well known to the profession through former editions, and has been highly appreciated. The work is divided into three parts. The first part takes up the physical and chemical properties of the urine, in health and disease, and the methods of examining the same chemically and microscopically. The second part treats of "Urinary diseses" viz., diabetes, gravel, calculus and chylous urine, in which the author not only gives the results of his own experience, but also all recent accepted facts in connection with these diseases. The third and most valuable part is devoted to the consideration of organic diseases of the kidneys, acute and chronic. The entire work is of a clinical and practical character, and will be found a reliable guide in the treatment of these diseases.

BODILY DEFORMITIES AND THEIR TREATMENT, A HANDBOOK OF PRACTICAL ORTHOPŒDICS, by H. A. Reeves, F.R.C.S. Eng., London Royal Orthopœdic Hospital, with 228 illustrations. Philadelphia: P. Blakiston Son & Co. Toronto: Willing & Co., $2.25.

The author deals with his subject in a most thorough and comprehensive manner, and gives us the full benefit of his large and extended experience in the treatment of this class of affections. Some subjects quite new to British surgery will be found in this book, for example, "Spring Finger, Paralytic dislocations, new operation for Nasal Depression etc. The work has been written from the standpoint of a general surgeon interested in this special domain, and the author endeavors to show that success in the treatment of orthopœdic cases depends very largely on extensive experience, personal supervision, and watchful care.

HAND-BOOK ON THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES, by Arthur Van Harlingen, M.D., Prof. of Skin Diseases; Philadelphia Polyclinic etc. Philadelphia: P. Blakiston Son & Co. Toronto: Willing & Co. Price $1.75.

The above will be found a useful little work on skin diseases, adapted to the wants of the general practitioner. It is chiefly devoted to the clinical features, diagnosis and treatment of the various diseases. The diseases are taken up in alphabetical order, in order to facilitate ready reference.

THE OLEATES, THEIR NATURE AND ACTION, by J. V. Shoemaker, A.M., M D., Prof. of Dermatology, Jefferson Medical College. Philadelphia: F. A. Davis, att'y. Toronto: Willing & Co.

SURGICAL PATHOLOGY, by A. J. Pepper, F.R.C.S., St. Mary's Hospital, London.

SURGICAL DIAGNOSIS, by A. P. Gould, F.R.C.S., Middlesex Hospital, London.

THE DISSECTOR'S MANUAL, by W. B. Clark and C. B. Lockwood, F.R.C.S., St. Bartholomew's Hospital.

INTESTINAL OBSTRUCTION AND TREATMENT, by Fred. Treves, F.R.C.S., London Hospital.

The above together with a work on Materia Medica, by Mitchell Bruce, constitute a series of clinical manuals for practitioners and students of medicine, published by Lea Bros. & Co, Philadelphia. They are edited by well known authorities in England, and issued in pocket size, 12 mo. volumes of 300 to 500 pages, well illustrated, and at a low price. The works are not pretentious, but will serve a useful purpose as books of reference on the subjects upon which they treat.

A TREATISE ON HEMORRHOIDAL DISEASE, ITS HISTORY, NATURE, CAUSES, DIAGNOSIS AND TREATMENT, by Wm. Bodenhamer, A.M., M.D. New York: Wm. Wood & Co. Toronto: Hart & Co.

We believe this is the only work on the subject of hemorrhoids published; at all events on this side of the Atlantic. This treatise will be found to be a complete encyclopædia on the subject, and will repay a careful perusal. As a work of reference it cannot be excelled.

HAY FFVER, AND ITS SUCCESSFUL TREATMENT BY SUPERFICIAL ORGANIC ALTERATION OF THE NASAL MUCOUS MEMBRANE. By Charles E. Sajous, M.D. Illustrated by 13 Wood Engravings. Philadelphia: F. A. Davis, 1217 Filbert Street.

Births, Marriages and Deaths.

On the 11th ult., Dr. J. W. Walden, of Waterloo, aged 47.

On the 20th ult., Dr. Joseph Mothersill, of Stratford, aged 65 years.

On the 28th ult., H. L. Vercoe, M.D., of Toronto, aged 45 years.

On the 20th ult., Fanny Creighton, beloved wife of Dr. L. F. Millar, of Woodhill, aged 28 years.

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